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The Aseptic Ritual and the Surgeon

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richelangelo's epigram that perfection is made up of trifles comes naturally to mind in connection with the subject of aseptic technique, and the train of thought is a perfectly logical one. Aseptic technique is based upon principles but it is made up of details, and carelessness in regard to any one of them, however trivial and unimportant it may seem, can mean ultimately the loss of a human life.

In January and February, 1927, there occurred at the Sloane Hospital for Women, New York City, a series of cases of streptococcal infection which, to quote the hospi-

tal authorities, "in their mode of incidence and in their severity constituted a veritable epidemic." Of the women delivered during that period, approximately 15 per cent showed evidence of infection, and of those infected 36 per cent died.

The surgeon can adequately fulfillhis personal responsibility to the patient on whom he operates only if he is upheld by every member of the hospital staff. This paper, written by surgeons, should not only be read thoughtfully and carefully by superintendents, surgical supervisors and other operating room personnel, but also should be brought to the attention of every member of

the surgical staff.

perience, and the problem that confronted the director of the hospital, Dr. Benjamin P. Watson, the bacteriologist, Dr. Frank L. Meleney, whom he called to his assistance, and their respective staffs was an enormous one. As soon as it was realized that an epidemic was actually in progress every conceivable precaution was taken. The strictest aseptic and antiseptic measures were instituted, mechanical and physical factors of contamination were excluded, the personnel, professional and nonprofessional, were studied as possible carriers, but the out-

Few men of this generation

have been through such an ex-

break was not curbed till admissions were stopped.

When the whole experience was a closed book and when the investigation was as complete as modern science could make it, the men who had lived through the nightmare published the story of

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it in every detail. That publication¹ is a shining example of honesty in the practice of medicine, just as it is a tragic illustration of what can happen in this day of supposed safety in surgery—from the standpoint of asepsis the practice of obstetrics is a purely surgical specialty—in an institution equipped with every modern safeguard and directed and staffed by some of the ablest obstetricians in the world.

The Cause of the Epidemic

The investigation, both Doctor Watson and Doctor Meleney frankly admit, was in many respects unsatisfactory and inconclusive, but there seems no shadow of doubt that contamination was introduced not as an autogenous infection, not through the failure of mechanical and chemical methods of sterilization, but simply because one apparently trivial and unimportant detail in the aseptic ritual was overlooked. During the early stages of the epidemic masks were not worn antepartum and postpartum by either physicians or nurses, and during parturition only the mouths were masked. When possible avenues of infection began to be studied, it was found that twenty-five of the 186 members of the hospital personnel harbored in the upper respiratory tract streptococci either of the same strain responsible for the epidemic or of an analogous strain.

The sequence of events is plain: Certain individuals who came into contact with the parturient and puerperal women were carriers of a virulent infection, transmission was possible because masking was inadequate, twenty-five women contracted puerperal sepsis as a result, and nine of those twenty-five died. The aseptic technique of the Sloane Hospital was to all appearances impeccable, but the overlooking of a single, seemingly unimportant detail resulted in catastrophe and terminated in a veritable holocaust.

Asepsis in surgery is not, as it was in Lister's day, a matter of antisepsis. Indeed, we would state without reservation that surgery based on antisepsis is often actually unsafe. It gives to the surgeon a false sense of security; a surprisingly large number of otherwise excellent surgeons still do not seem to realize that bright colors do not of themselves kill germs. Strong chemicals may damage the tissues of the body long before they kill the organisms they were applied to destroy. Nor is asepsis in surgery merely a more or less routine adherence to a formal, meaningless ritual of time and temperature. It is that but a great deal more.

Listerian surgery, Garrison says, is almost as exact and reliable a science as bookkeeping, and so it is, but only when every member of the operating room staff, from the chief of the service down to the humblest orderly, comprehends, because he has been trained and taught to comprehend, that upon him as an individual depend the well-being and the very life of every patient who enters the operating room. There are possibilities of danger in every operation which are appreciated exactly in proportion to the skill and experience of the man who performs it and which are comprehended by those associated with him exactly in proportion to the emphasis he himself puts upon them.

Those potentialities, those risks, are inherent in minor operations as well as in major procedures. When the laws of asepsis are transgressed there is no such thing as minor surgery. Even though a pin prick may no longer open the doors of death and an abdominal operation need no longer be classed among the methods of the executioner, it might profit us all to consider carefully the full implications of the surgery we are wont to regard so lightly, and to contemplate earnestly and seriously the consequences that may flow from it. The patient in many an operating room today is regarded as a mere lay figure upon whom various abstract rites are practiced, but as a matter of fact he is the person who pays the piper even though the surgeon and his associates may call the tune.

Surgeon Must Set a Good Example

The surgeon himself is responsible in the last analysis for what goes on in the operating room in which he does his work. The intern staff, the nursing staff, the nonprofessional workers, may and do carry out all but the actual operative act. But upon the surgeon himself rests the final responsibility, and upon his mental outlook, his cultivated conscience, his sense of moral values, rest the standard and the performance of the whole operating room personnel. His first duty is to set before assistants, interns, nurses and nonprofessional workers an example of aseptic conscience, an example of absolute, unvarying, unremitting, eternally accurate attention to details. The surgeon may be at the mercy of his assistants, but the surgeon whose aseptic ideals are what they should be, and whose performance cleaves to his ideals, is likely to have a corps of associates who will always hold up his hands.

Every operation, Moynihan has well said, is an experiment in bacteriology. How successful that experiment will be depends in the final analysis upon the surgeon and upon the standards that he has set for himself and for his staff. The clean surgical wound that becomes infected is a blot upon his record, for such an infection must always, until it can be proved otherwise, be traced straight back to the surgeon who made the wound. A surgeon

¹American Journal of Obstetrics, Aug., 1928, pp. 157-194.

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cannot expect in his assistants what he does not exhibit himself. Germs are no respecters of persons. An internationally famous surgeon can no more preserve his sterility if, as he waits for his anesthesia to be completed, he clasps his sterile hands behind his unsterile back than can a tyro remain free from contamination if he is consciously careless in his technique. In either case the effect on the morale of the operating room staff is precisely the same. If the man who should set the example sets none, or sets the wrong one, his subordinates find in his performance the justification for their own laxity, and again the patient pays.

Complicated methods, however, are neither necessary nor desirable. In the craft of surgery, as Moynihan truly says, the master word is simplicity, and the basis of a safe aseptic technique is exceedingly simple: no sterile person touches anything that is unsterile, and no unsterile person touches anything that is sterile except with sterilized forceps. The observance of these two rules either would prevent any break in technique or would detect the break immediately it had occurred and so obviate its dangers.

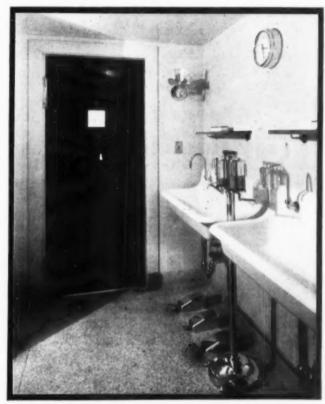
A certain amount of individuality is inevitable in all walks of life, and is not necessarily undesirable even in surgery. But there is no reason, no excuse, for the exhibition of personal preferences which some surgeons give in the operating room. Such a practice makes life burdensome for the staff and adds in no degree to the safety of the patient. Individualism under such circumstances is little more than selfishness run mad, and the inevitable result is chaos. No surgeon's prestige suffers because he submits himself to certain reasonable general rules. It would be better if his urge for self-expression manifested itself in his performance, in a rigid adherence to the laws of asepsis which promote the safety of surgery.

The Chief Sources of Danger

Perfection of technique is achieved not by the institution of complicated individual methods but by constant, careful repetition of the conscious act until it finally becomes automatic and unconscious, until it is a very part of one's being. It must be recognized, of course, that in the transition from the conscious to the unconscious act there is a certain degree of danger. Practice does not always make perfect. More than one psychologist has pointed out the risk of perfecting errors by constant repetition, and it would pay every surgeon to take stock of his technique at intervals to be certain that he is not perpetuating errors himself and countenancing their perpetuation by those about him. The surgeon, W. J. Mayo says, is dan-

gerous enough when he has his eyes open, and Finney, with equal correctness, writes of the absolute certainty of error somewhere as long as human nature is human nature.

The chief sources of danger in an operating room today are not so much overt as covert. The system is usually correct in principle; the individual simply errs in carrying it out. It goes without saying that the surgeon and his immediate



A well equipped scrub-up room is essential in preparing the hands and forearms for operating. This is a typical room at Touro Infirmary, New Orleans.

assistants prepare themselves for operating by a certain ritual, but it does not follow that the mere donning of sterilized gowns and gloves confers upon them a permanent immunity against contamination, permits them to brush against unsterile walls, to handle unsterile objects, to roam from room to room as they will or to commit similar offenses against asepsis. Nor should it be forgotten that every person who enters an operating room plays at least an indirect part in the operative act. No matter what his function, no matter how brief his stay, he should prepare for his entrance by donning the proper operating room clothing and to wear a mask should be obligatory.

Antiseptic solutions in the preparation of the hands are unwise if for no other reason than that even the weakest solution used over a long period of time injures the tissues and so paves the way for infection. Other things being equal, adequate

scrubbing of the hands and forearms with soap and in running water, careful cleansing of the nails, and a final rinsing with alcohol to remove grease and excess soap, constitute a safe and simple method of preparation. The important factor is mechanical cleansing for a sufficient length of time in a medium that is clean to begin with and that stays clean—which does not mean a basin of water, even though the water be religiously changed.

A False Sense of Security

Gloves cannot be considered sterile unless they are put on so that the outer surfaces are not touched with the bare hand. Moreover, when they are once put on, it must be sedulously borne in mind that the gloved hand is not thereafter to touch objects that are not surgically clean, or, for that matter, to touch objects that are surgically clean if there is any way to avoid touching them. A further precaution might well be emphasized: If the glove is punctured or torn during operation it should be changed promptly. Most surgeons realize fully that the bare hand is not sterile and cannot be made sterile, but they are prone to forget that while gloves may be a tremendous protection to both patient and surgeon, they may, like antiseptics, engender a totally false sense of security if they are not properly employed.

In the preparation of instruments and linen the most important consideration is not the method of sterilization, although the autoclave method is generally admitted to be best, but the institution of routine checks by the department of bacteriology, to make certain that sterilization is really adequate and that protection is really thorough. No method is safe or satisfactory that is not so checked. Preparation of ligatures no longer concerns the individual hospital, for reliable commercial houses today do the work much better than any hospital staff could, but again it must be remembered that the persons handling ligatures in any capacity in the operating room are the persons finally responsible for them. No matter how carefully a ligature is prepared originally, it becomes unsafe when it is carelessly handled.

Every possible method of skin disinfection has been tried. None of them is bacteriologically perfect and all of them are based upon the use first of a fat solvent and second of a tanning or fixing agent, after preliminary mechanical cleansing with soap, water and alcohol. It is just as impossible adequately to sterilize the human abdomen as it is to sterilize the human hand. Bright colors, as we have already pointed out, do not protect, and strong chemicals may do harm. Safety does not lie so much in the particular antiseptic used as in

the careful protection of the wound edges by towels so closely affixed to them that they serve as a mechanical barrier and prevent the brushing of the contents of open sweat glands and hair follicles into the wound cavity. The surgeon who keeps his hands off skin surfaces and who allows the skin preparation to be done by his assistants before—not after—they have finally prepared themselves for the act of operating, will reduce his wound infections from this particular source to an irreducible minimum.

An exceedingly important precaution, and one which is frequently overlooked, is that instruments that are soiled during operation should be promptly discarded and should not be used again. It is well to emphasize the fact that "soiled" does not necessarily mean contaminated by pus. The instrument which has come into actual or possible contact with cancer cells is death dealing, for of the transplantation of cells there can no longer be any reasonable doubt. The red handkerchief on which Moynihan places his soiled instruments during operation may seem an unnecessarily theatrical touch, but the potentialities of danger are grave enough to warrant the use of any method that will direct the surgeon's attention to the risks associated with his work.

Greater Care Needed in Sponge Count

The sponge count is a matter not so much of method as of scrupulous, unremitting care. The most perfect of methods still carries a chance of error because the human equation cannot be eliminated and every person in the operating room should be taught the gravity of an inaccurate sponge count and the consequences that may arise from carelessness. In more than 200 cases collected by Crossen in which a sponge had been left in the abdominal cavity, there was a 25 per cent mortality, and the fact that 20 per cent of the cases were recognized only at postmortem strengthens the view that a great number of such accidents are never recognized because no necropsy is done and therefore the real cause of death is never determined. Every method ever employed has broken down at some time, not because the method was faulty but because the persons employing it were careless, and the solution of the problem, therefore, is not more complicated precautions but a greater degree of care.

The surgeon's own procedure is just as much a part of the aseptic ritual as are the sterilization of his instruments and the preparation of his hands. Extreme gentleness is the first requisite: A patient under anesthesia is still a patient who can record sensation and who can lose his life if the tissues of his body are too grossly insulted. Even though

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that time, it would be well for every surgeon to remember the advice given 125 years ago by an old physician of Guy's Hospital: "Do not cleanse the sore too curiously." It would be well likewise if there could be placed conspicuously in every operating room a sentence from Novalis, "We touch heaven when we lay hands on the human body," for the responsibilities of surgery are too often taken too lightly.

The second essential is a certain degree of speed. There is an old Italian proverb, "He who goes slowly goes safely, he who goes safely goes slowly," and it is perfectly true in surgery, but with reservations. Speed in an operation does not count so much as that no time should be wasted in purposeless motions. Speaking categorically, when the patient is kept on the operating table more than an hour, other things being equal, something is very wrong, perhaps with the patient, but more often with his surgeon. Reflection should precede performance, but the operating table is not the place for meditation. It is the place for action, and every operation should be performed with as much speed as is consistent with safety.

Last of all, the surgeon should keep his composure. The surgeon who explains that he loses his temper in the operating room only out of consideration for his patient may deceive himself, but

he deceives nobody else. Errors in technique are all too frequently the fault of the surgeon who by the loss of his own composure affects the poise of all his associates, slows up the tempo of the operation, and actually does his patient harm.

When failure comes in surgery now, says Lord Moynihan, it is the individual who fails, not the methods of which Lister laid the eternal and unshakable foundations, and the corollary of that pronouncement is the unqualified statement that only by a routine, systematic, impartial check of every case operated on in an institution can the efficacy of the aseptic technique employed in it be evaluated and the defects of the system and of the individual surgeon be realized. Every wound infection demands a searching inquiry as to the reason for its occurrence and the means of preventing a recurrence. In the average hospital today which is governed by acceptable regulations and staffed by approved men, the system is not likely to be greatly at fault, and the responsibility comes back to the individual. The conclusion of the whole matter, therefore, is that the surgeon himself must in the last analysis assume the responsibility for everything that happens to the patient he is operating on. No sophistry, no casuistry, can free him from blame when things go wrong, and, as a consequence, it behooves the surgeon to exercise unremitting care, to be certain that things go right.

The Incapable Surgeon—How to Deal With Him

What should be done with a hospital surgeon who has a persistently high operative mortality? This question has been asked by a hospital superintendent upon whose staff there is a surgeon of average ability whose operative mortality percentage is persistently high.

The answer to this question is one of great delicacy. To brand a surgeon as inefficient is a serious matter. The great variety of conditions which affect prompt recovery following surgical operations makes comparison with the work of other surgeons difficult. Yet when such accidents as postoperative infection, the discovery of foreign bodies in the peritoneal cavity or the exercise of palpable bad surgical judgment are brought to light, action must be taken.

Each Death Should Be Reviewed

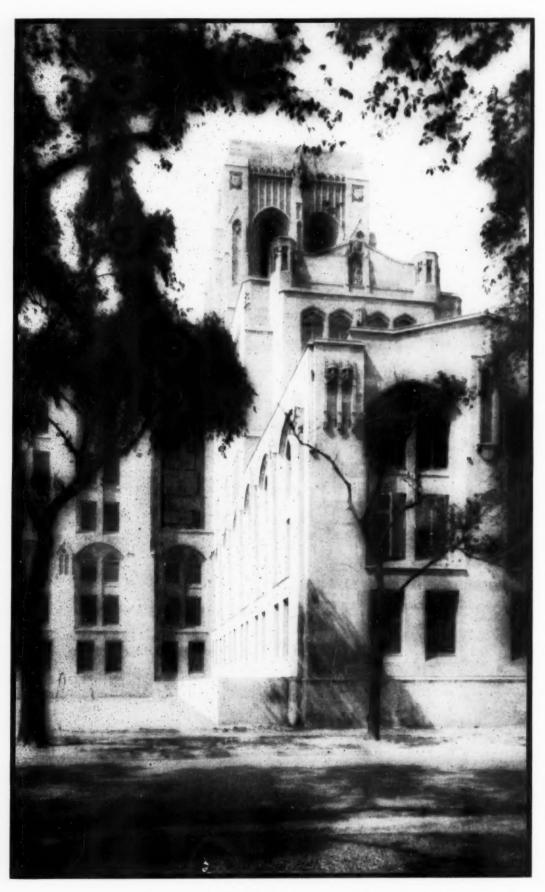
A comparison of mortality statistics from year to year with other hospitals or with those of surgeons on the hospital staff is considered a healthy measure. If gallbladder surgery, for example, as performed by the surgeon being investigated yields a mortality of 20 per cent, whereas the general average is 10 per cent in other institutions, there must be a cause. If operations are unduly prolonged or if postoperative infection occurs, a frequent checking of errors in technique might bring to light interesting facts. Members of the surgical staff organized as a surgical conference should review each death. If they are unwilling or unable to assume this responsibility then the medical

administrator of the hospital must step in. If there is any doubt as to the capabilities of a hospital surgeon, no stone must be left unturned to protect the institution's clientele, no matter whose feelings are injured.

Release of One Party From Liability Relieves All Others

The plaintiff was injured in an automobile accident and was taken to the defendant hospital for treatment. Later he sued the hospital for damages, claiming that through the negligence of certain of its employees his injuries were aggravated. The hospital contended that he was barred from bringing the action because, for a consideration, he had released the person responsible for the automobile accident from all liability.

A person, said the Supreme Court of Florida, division B, who has negligently injured another is liable in damages for any aggravation of those injuries due to the malpractice of a hospital or physician, if the injured person has used care in selecting the hospital or physician. The hospital or physician aggravating the original injury is jointly and severally liable with the original wrongdoer. A release from liability to one of the parties jointly or severally liable operates as a release to all other parties liable. Therefore, the release to the original wrongdoer operated to release the hospital from liability.—Feinstone versus Allison Hospital, Inc. (Fla.), 143 So. 251.



The East Tower of the University of Chicago Clinics

Hospital Organization Series

Under the direction of Dr. WINFORD H. SMITH

How to Organize the Hospital's Accounting Department

By WALTER E. LIST, M.D.

Superintendent, Jewish Hospital, Cincinnati

ACCOUNTING has only one correct principle and this principle can be applied to hospitals as well as to any other line of business. Certain features in the application of this principle to hospital accounting, however, require special forms which are peculiar to hospitals.

Every hospital accounting system should be designed so as to ensure: (1) a correct record of all funds received; (2) a correct record of all funds expended; (3) a correct record of all materials purchased and used; (4) that the proper department is charged for all materials used and that each department is credited for its income; (5) that monthly and annual reports are prepared of all the activities of the institution, both financial and statistical; (6) that a complete and concise picture of the financial condition of the hospital at all times is provided for the superintendent.

The superintendent may ask how many people it will take to establish such a system. To answer

this question, let us take an institution of average size, plan for it a theoretical accounting organization, and analyze the duties of each individual.

Let us say that the cashier receives all cash coming into the hospital regardless of how it is to be applied. A receipt book is provided for her use. This form is in duplicate, and has five receipts on a page with columns at the side for the distribution of the cash to the various accounts to which it is to be applied. The payer receives the original receipt. The cashier retains the copy together with the information as to who made the payment and for whom it was made, as well as the proper income accounts to be credited. At the close of each day the cashier makes a report to the general bookkeeper of all cash received and deposited. The general bookkeeper enters this in a general cash receipt register (Fig. 1). This register is footed and posted to the general ledger at the end of each month's business. A petty cash fund for

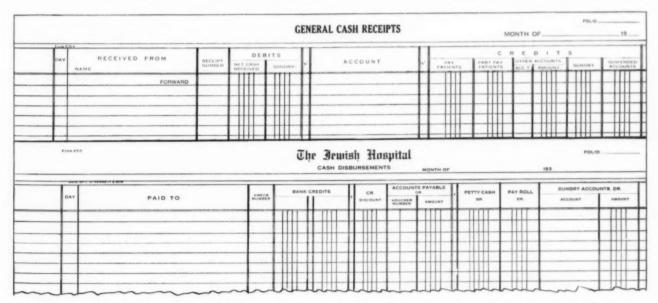


Fig. 1. A section of the general cash receipt register is shown at the top, and at the bottom, a part of the cash disbursement register.

making refunds is placed at the cashier's disposal, and a report on this fund is made to the general bookkeeper at least once a week, or whenever the fund is low. All monies are deposited on the same day they are received. The cashier is in charge of delinquent accounts and should be experienced in collection work.

The duties of the accounts receivable bookkeeper are important. Charges to patients for services rendered originate in the various departments. The forms used for these charges show the

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Fig. 2. The patient's ledger card.

department, the date, the name of the patient, the room or the ward number, the patient's address and the name of the physician. There is also a space for listing the various services. The books containing these forms are made in two sets in duplicate. One set is marked A and the other is marked B. The A set is used while the B set is being priced by the accounts receivable bookkeeper, and vice versa. The originals are detached by the accounts receivable bookkeeper and entered on the patients' accounts.

In the last few years, hospitals have come to recognize the value of modern computing, adding and accounting machines, first as an aid to efficiency, as machines permit closer control of financing, and second as an economy measure in labor used in operating the business office. Computing machines are used in the purchasing department to check all invoices received. The

quantities are calculated by unit prices, and the extensions are verified. In addition to the usual adding machines, modern electric bookkeeping machines are needed in the bookkeeping office. With these machines it is possible to post to the patient's ledger and bill, and at the same time automatically balance the account after each day's posting. In this way, bills are ready for presentation at a moment's notice, and also a grand total of the entire day's posting is thus secured.

The patient's ledger card (Fig. 2) shows all the charges for the period that a patient is confined to the institution. The invoice shows the same detail as the ledger card. Advance payment for services is usually secured by the admitting department, but should this department fail to secure payment in advance a statement is sent to the patient showing the amount due. Statements are sent to the proper persons at the end of each week corresponding with the patient's day of entry into the hospital.

The cashier and the accounts receivable bookkeeper should be in close proximity to each other as their work requires close cooperation.

The accounts receivable bookkeeper keeps a daily summary of the analysis of all the charges and credits to patients (Fig. 3). This work may by done by machine. This summary is totaled at the end of each month and given to the general bookkeeper for entry into the general ledger.

The general bookkeeper is in complete charge of the entire bookkeeping system and supervises all the work pertaining to it.

The departmental pay roll originates in each department. The following data are listed on the pay roll sheet: the name of the employee; his position; the time on duty; the rate per day, week or month; the amount of wages earned; the deductions, and the net amount to be paid. A column is provided for an explanation of the deduc-This form is sent to the general bookkeeper at the end of a predetermined period for entry into the general pay roll. The departmental pay roll is used only for the workers who are not on a monthly basis. The general bookkeeper is provided with a pay roll form on which is placed the account number; the name of the employee; the occupation; the time worked; the rate; the amount; the deductions, and the net amount paid. Space is provided also for the listing check number and any necessary remarks. The general bookkeeper has a list of all the employees paid on a monthly basis, and makes up the pay roll.

An employees' record is kept in the bookkeeping office, showing the name; the address; the department in which employed; the position; the rate of pay; the date of employment, and the rea-

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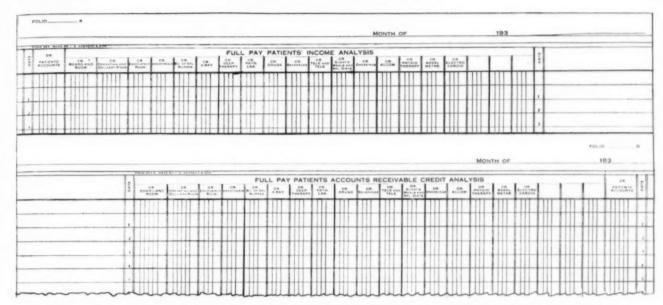


Fig. 3. The accounts receivable bookkeeper keeps a daily summary of the analysis of all the charges and credits to patients on these two forms.

son for separation from the service. On the reverse side of the employees' record card is a record of the number of days off and the reasons for absence. This information is obtained from the department heads. The monthly pay roll is made up from this record. It is a good plan to list the employees' names by departments in making up the general pay roll to simplify posting.

All purchases are made on a purchase order in quadruplicate. The original is sent to the vendor, the duplicate to the general bookkeeper, the triplicate either to the storeroom or the receiving clerk and the quadruplicate either to the superintendent or the department for which the material is ordered. The receiving clerk receives all deliveries to the hospital, and makes out a receiving slip in duplicate. The receiving slip is sent to the general bookkeeper for authority to approve the vendor's invoice for payment. All materials returned to the vendor are sent through the receiving department. The receiving clerk fills out a return slip in duplicate and sends the original to the general bookkeeper for authority either to deduct the proper amount from the vendor's invoice or provide him with a credit memorandum.

After receiving the duplicate purchase order and the receiving slip showing the receipt of the goods, the vendor's invoice may be passed for payment. A voucher (Fig. 4) is then made up to show the account to which the material is to be charged, the name of the vendor, the vendor's address and the date the goods were received. Space is provided to list the invoices should there be more than one, and also to list the check when payment is made. After the vouchers are made up at the end of each month's business they are entered in

a voucher register. The voucher register is provided in both long and short pages so that the outside length may be shortened in order not to take up too much space. Columns are provided for an analysis of practically all of the expense accounts, the name of the vendors and a credit to accounts payable.

The voucher register is footed and posted to the general ledger at the end of each month's business. Small payments of cash may be made through the petty cash fund. A receipt is taken and a refund from the general cash is made for the amount of



Fig. 4. This voucher is used to record goods received.

the receipts taken. Payments are entered in the cash disbursement register (Fig. 1). The cash disbursement register has columns for the petty cash and pay roll disbursements.

All purchases pass through the general storeroom, and no supplies are given out from the storeroom without a requisition. Each requisition is made out in duplicate and must be properly signed. Both copies of a requisition are sent to the storeroom where the order is filled and the prices and extensions are entered on each copy. The original copy is detached and the duplicate is returned to the department with the supplies ordered. In this way the department head is advised as to the cost of the supplies, which is an influence toward economy. The storeroom clerk enters each requisition on the storeroom record and makes an analysis of the supplies by departments. This is done on a multicolumnar paper. The storeroom record gives all the necessary information concerning the supply in question, such as the name of the product, its location, the name of the vendor, the minimum amount before ordering, the maximum amount to order, the amount received, the value of goods received, the amount disbursed, the balance on hand and the value of the balance on hand. This record is kept in visible index form. It is kept up daily in order to provide an accurate record of the supplies on hand. After an analysis of the requisitions is made, the storeroom record is sent to the general bookkeeper for proper journal entry.

The general ledger contains a record of the

capital accounts (land, buildings, furniture and fixtures), cash and other current assets, as well as capital and current liabilities.

The general bookkeeper makes out a monthly report of all activities of the institution at the end of each calendar month. The various departmental reports also are filled out by the general bookkeeper and typed by the bookkeeping department. The departmental reports show the earnings and expenses for the month in comparison with other periods, as well as in comparison with the budget figures. The departmental reports also list the supplies used and the repairs and replacements made. Data on the cost per meal, the number of meals served in the dietary department, the number of tons of coal used, the pounds of steam generated, the cost per 1,000 pounds of steam for coal used in the power house, the number of pounds of laundry and the cost per pound of laundry washed in the laundry, also are listed on the departmental reports.

The work that has been outlined can be done with a corps of six persons, including a cashier, an accounts receivable bookkeeper, a general bookkeeper, a storeroom clerk, a storekeeper and a director of purchases.

It is highly desirable that all hospitals adopt a standard form of charts of accounts. The chart of accounts as set up by the Hospital Council of Cleveland, which has been approved by the American Hospital Association and the Ohio Hospital Association, is the one used in this discussion.

Ways to Promote Efficient Operating Room Management

The detailed management of the operating room, that is, the putting into effect of the rules and the carrying out of the prescribed technique, belongs to the operating room supervisor, but always with the proviso that the surgeons working in the institution should feel free to offer constructive criticism. This opinion was expressed by Dr. Max W. Myer, director of surgery, Jewish Hospital, St. Louis, at the clinical congress of the American College of Surgeons, Hospital Standardization Conference, held at St. Louis.

A fixed personnel is vitally important in the operating room, according to Doctor Myer. A graduate nurse with much experience should be at the instrument table for all major cases. There is no position in this department more vital for good or evil. This is no place for the undergraduate nurse. She can receive all the training required in the minor cases and as assistant nurse at the table. The graduate nurse at this position can direct the set-up of the room and manage the details during an operation, making it possible for the supervisor to move about freely and keep an eagle eye upon the entire suite.

"In our institution," Doctor Myer said, "we have attempted to have our operating room technique as simple,

but as proficient as possible. Since the hospital has supplied all instruments, gloves, suture materials and other similar items, it has helped much in this regard. We find the surgeons much more willing to accept the routine layout of instruments and to get away from the unnecessary use of special instruments, although an occasional man will insist on bringing his own instruments or in making use of his own pet needle holder or scissors.

"Our surgical dressings, which follow in a liberal way the standardized dressings, meet the requirements of the great majority of our men, but here, too, there are a few who insist on something special. When a new group of interns come to the operating room we make bacteriologic checks on their hands after washing, more for the moral effect than for any real result which we hope to obtain.

"The records of all cases with complete physical and urinary analyses are required before any general anesthetic can be given. The patients are required to be in the hospital for four hours before a general anesthetic is given, except in emergency cases and in tonsil cases. In the latter, the surgeon in charge of the case is responsible. For spinal anesthesia we have a complete set-up, which makes it unnecessary for the operating team to take any part in this procedure. We attempt to have all infections in the hospital reported so as to have a record of them and to make possible a search for the cause in each case."

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Payne Whitney Clinic Offers Complete Care for Mental Patients

By WILLIAM L. RUSSELL, M.D.

New York City

THE importance of psychiatry in modern medicine and medical education is notably illustrated by the psychiatric facilities at the new hospital and college of the New York Hospital in association with Cornell University Medical College. Among the buildings comprising this development, the Payne Whitney Psychiatric Clinic has a conspicuous place. This building, with accommodations for 111 patients, is designed for study and treatment of all forms and degrees of psychiatric disorders, from the milder personality maladjustments and psychoneurotic disturbances to the more severe psychotic reactions, as well as for teaching and scientific research.

Advantageously situated on a bluff beside the

East River near the main entrance to the hospital premises, the clinic faces the open grounds in front of the hospital and is well removed from busy streets and from residential and industrial buildings. It is flanked on one side by the Children's Clinic, a complete pediatric hospital, from which it is separated by an enclosed garden. On the other side are the grounds and buildings of the Rockefeller Institute. In the rear is the river. From the windows of the clinic views of sky, city and river, with Welfare Island in the distance, are extensive and of never failing interest.

In appearance, the clinic building resembles the group described in detail in THE MODERN HOSPITAL for March, 1933, although there is sufficient differ-



A fully equipped art studio for occupational therapy is one feature of the clinic's equipment.

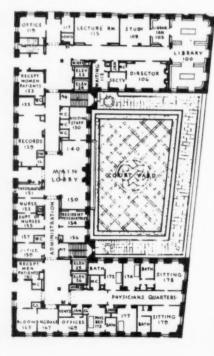
ence to lend individuality. There is nothing in the appearance of the building to suggest isolation or unhappy associations. The building, which is 180 feet long, extends around three sides of a court. The wings and court face the southeast and the river. This arrangement permits abundant sunshine to enter patients' rooms and offers a wide outlook from the windows. The front of the building rises eight stories above ground and, due to the contour of the site, two additional stories are above ground on the side facing the river. This extra space has been used for clinical and teaching services. A penthouse on the roof serves as an animal house. The roofs of the wings are equipped for patients' use.

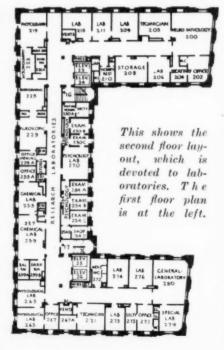
Environment Important for Mental Patients

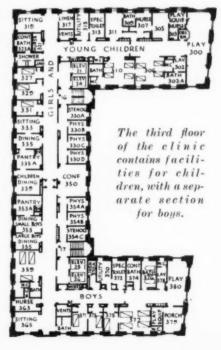
In planning, constructing, equipping and furnishing the building, the purpose to be served was the guiding principle. The aim was to produce a structure free from indications of seclusion but providing sufficient privacy and safety; having a domestic rather than an institutional aspect; with adequate accommodations for the classification. study, and treatment of patients in accordance with the condition and needs of various types; with freedom from disturbing noises and objectionable contacts, and with satisfactory provision for medical and economic administration. It was also necessary to provide for out-patient service, for the teaching of a body of students and for scientific research. So far as needs could be anticipated and conditions permitted, these purposes have determined the character of the development. The following description is presented with the hope that it may prove helpful to those who contemplate

psychiatric provision, great or small, either in the form of new hospitals or of alterations in existing structures.

In shaping plans for the clinic, the importance of environment in the treatment of psychiatric patients was kept constantly in view. An endeavor was made to provide the appearance, comforts and personal conveniences of a dwelling place. The entrance lobby and reception rooms for patients were finished and furnished with this object in mind. Bedrooms, sitting rooms, dining rooms, general social rooms and corridors for patients resemble, in great measure, rooms in a comfortable home. Bedrooms, except those for restless patients, are equipped with individual lavatories, and a number are connected with bathrooms. Adequate toilet and bath facilities are found throughout. Every bedroom has a clothes closet. Bedside lamps are supplied for patients who can use them advantageously. A barber is employed and rooms equipped for his use are provided on several floors. Two sitting rooms in each section permit satisfactory grouping and separation of patients. One of these rooms is at the end of the wing overlooking the river, and connects with an adjoining glazed porch on one side and an open loggia on the other. Each dining room, domestic in character, accommodates only the patients of the section in which it is located. Provision is made for parlor games. Pianos are supplied in a number of the sitting rooms and in the social rooms on the top floor. A circulating library is available for the use of clinic patients, and books and magazines are supplied in the social rooms and section sitting rooms. The large lecture room designed for students is equipped with theater chairs and may be used for moving pictures







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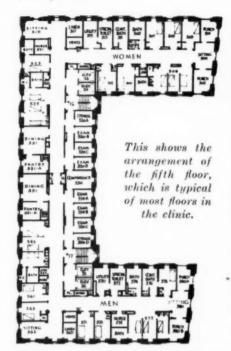
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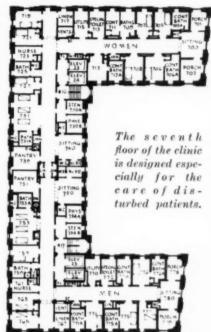
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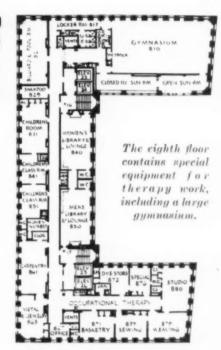
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and other forms of entertainment for patients.

Accommodations for patients occupy five floors, beginning with the third which is designed for children. Patients who require the closest attention are assigned to the two upper floors. Each floor is divided into two sections, connected by a short corridor with a door at either end. Thus, there are ten sections, each self-contained, suitable for men or women and accommodating ten to twelve patients. This permits classification by sexes and according to varying needs and conditions. Bedrooms and sitting rooms are so placed that patients may also be grouped or separated within the sections as may be required for their comfort and treatment. On the fourth floor are single bedrooms only, a number of which have connecting bathrooms. On the other floors, besides single rooms, are a few dormitories, none of which contains more than three beds. Each dormitory has a connecting bath and toilet room.

Doors Made to Close Silently

Partitions are constructed of blocks that have been tested for strength and weight at approved laboratories and have been found resistive to sound transmission. Rooms for restless patients are surrounded by double partitions of this material, in which is a half-inch air space lined with hair felt. Partitions of this type also protect the physicians' consulting offices from disturbance and prevent the transmission of sounds from pantries. Lime plaster was used for walls, rough troweled except where a smooth hard surface was required for sanitary purposes or for the protection of patients from injury. Corridor and sitting room ceilings are of sound absorbent material. Ceilings are hung

with an air space above. In bedrooms and bathrooms for talkative patients, in treatment rooms, in stenographers' offices and in other rooms in which penetrating sounds are made, ceilings are constructed of soundproof material, which produces good results.

Corridor floors are of oak strips laid diagonally in asphalt on concrete. Bedroom, sitting room and



There are over twenty offices for physicians. The one shown here is in the out-patient department.



The nursery school in the out-patient department is a fully equipped unit of the clinic. In the background is the one-way screen of the observation room.

dining room floors are of linoleum or linoleum blocks on concrete. Carpet runners and rugs add to the noiselessness of the floors. Windows are furnished with draperies and much of the furniture is upholstered. The substantial doors and trim are of wood, equipped with roller latches and friction hinges. Door panels in rooms for restless patients are double, a space between being lined with sound insulating asbestos. Double panels of unshatterable glass are made with an air space between. Doors are further silenced by means of rubber buffers in the jambs and on the bottoms where the space is closed by means of a device that operates with the clossing of the door.

Windows Are of Special Design

Air ducts of these rooms are carried along the corridor and connected individually with the main riser by a canvas sleeve. This prevents the conveyance of sounds from one room to another. Elevator shafts are well insulated and lobbies are shut off from the patients' accommodations by sound resisting partitions and doors. By these various means much has been accomplished toward a quiet environment.

Although patients seldom use the stairways, these are, as a precaution, enclosed in solid walls to avoid open wells. Doors leading to stairways and elevator lobbies are equipped with spring locks and automatic door closers. Windows accessible to patients are of a safety casement type, with an opening limited to five inches. They are glazed with 7 by 81/2-inch panes of unshatterable or thick plate glass and are controlled by a mechanical device operated by a small crank or knob which can be recessed and locked. A few bedroom windows are fitted with glass and screen shutters. Heat radiators in patients' rooms are covered. Rooms occupied by patients requiring special protection are heated by indirect radiation controlled by thermostat.

Hot water supplied to lavatories and baths is regulated at the source and is never hot enough to scald. As an additional precaution, automatic control valves and mixers are attached to continuous flow baths and showers. The water supply to individual lavatories may be locked off by the nurse when necessary. Bathrooms, treatment rooms and other rooms from which it may be necessary to summon extra help are equipped with alarm sig-

nals. To permit ready supervision of patients in their bedrooms, the glass upper panels of doors are covered with sash curtains on the outside. All patients' rooms are equipped with night lights set in glazed recesses near the floor, and controlled by switches outside the rooms. The doors of rooms designed for difficult patients open outward. Shallow finger pulls instead of knobs are used on the inside of the doors of these rooms as a precautionary measure.

Linen and Rubbish Chutes Are Kept Locked

Projections from which heavy objects could be suspended are, so far as possible, omitted in patients' rooms. Screws of the spanner type, removable only by means of a special tool, are used wherever their removal might be unwisely undertaken. Tacks and nails in furniture have been avoided whenever possible. Light fixtures in rooms for restless patients consist of shallow bowls of heavy glass closely attached to the ceiling. In other bedrooms simple indirect metal fixtures are used. To avoid the use of drinking glasses where they might be hazardous, jet drinking fountains to which ice water is circulated are installed on all floors of the building.

Roller latches and quietly operated cylinder



Roller latches eliminate the sharp snap of closing doors. Rubber buffers aid in closing doors noiselessly.



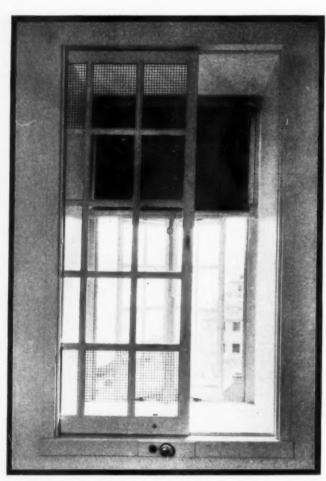
A directly connected one-piece irrigation table is invaluable in the treatment of resistive patients.

locks render as unobtrusive as possible the constant locking and unlocking of doors required in a psychiatric hospital. Linen and rubbish chutes are shut off by closet doors which are kept locked and by spring hinges and locks on the chute doors. Pantries are entered only through the dining rooms, except on one floor where there are no dining rooms. Knives and other dangerous articles are kept locked in drawers, keys to which are kept in the nurses' offices. These various precautions protect the patients, and at the same time impose a minimum of personal restraint and supervision.

Treatment Rooms on All Floors Except One

Diagnostic and treatment facilities are provided on all floors occupied by patients. More than twenty offices for the use of physicians are in subcorridors on these floors, directly accessible from the patients' quarters, the elevator lobbies and the stairways. Each section of the floors for patients contains a utility room equipped with sterilizers, sinks, warming and supply closets. On all floors except the one for convalescents there are fully equipped treatment rooms. In sections for restless patients these rooms are provided with irrigation tables connected directly with the plumbing system. Each section is equipped with at least one

continuous flow bath. For the more restless patients there is at least one tub to two patients. A number of these tubs are in bathrooms directly connected with single bedrooms. All sections are provided with shower baths as well as with the usual bath and toilet equipment. Detachable nurse calls which operate a light over the bedroom door are provided for all beds except those occupied by excited patients. The section pantries are equipped for light cooking, with warming tables and refrigerators, and are served directly from the kitchen by electric lifts. Nursing offices equipped with



The safety windows have an opening limited to five inches.

The windows have a glass and screen shutter.

sinks, medicine closets, chart racks and other equipment are provided for each section.

For forms of treatment requiring considerable space, equipment and organization, special provision is made somewhat apart from the residential sections. Three rooms on the out-patient floor are equipped for dentistry and oral hygiene. On the floor below space is assigned for hydrotherapy, light therapy and electrotherapy. The top floor of the building, with many windows commanding a wide prospect, is devoted entirely to therapeutic measures. Nine rooms equipped for carpentry,

metal work, basketry, needlework, weaving, painting, block printing and other crafts are given over to occupational therapy. Three rooms are equipped as classrooms and workrooms for children. Also on this floor are a gymnasium with showers and dressing rooms adjoining, a hair dressing room for women, a billiard room, an open and a glazed sun room, and two rooms designed for social activities. reading and music. The roofs are protected and are equipped for outdoor exercises, two enclosed courts and a garden also being used for recreational purposes. The clinic's dietary service, with a dietitian in charge, is housed in a kitchen in the building. Food is delivered to the pantries, directly above the kitchen, by enclosed electric lifts. Surgical operating rooms and all diagnostic, treatment and service facilities of the other departments of the hospital are easily accessible.

Out-Patient Service on Separate Floor

The third floor of the clinic is devoted to the study and treatment of children. It is divided into two sections corresponding to those of the other floors. Children of both sexes up to eight years of age, and girls up to fifteen are accommodated in one section. The other is designed for boys between eight and fifteen years of age. Each section is divided so as to permit sufficient segregation of children of different ages and types within the section. Equipment and furnishings of these sections correspond to those of the sections for adults, with such changes as are required by the ages of the children and their special needs. Playrooms with linoleum covered floors are substituted for some of the carpeted sitting rooms for adults. The same type of window is used, but the limit of opening is reduced to four inches. Provision is made for isolation as a precaution against infection and for the treatment of exceptionally difficult behavior problems. Classrooms and workrooms for children are found on the top floor and one of the protected roofs is equipped for their use.

The out-patient service is of great importance in extending the clinic's usefulness far beyond the point which can be reached by hospital study and treatment only. The out-patient floor is below ground on one side, but on the other three sides are full sized windows with a pleasant, sunny outlook. The approach is by an easy stairway, the entrance to which is at the front of the building, or by elevator from the main floor of the clinic. The waiting rooms are tastefully finished, with comfortable and attractive furnishings. The physicians' pleasant offices resemble modest private consulting rooms. In addition to twenty of these rooms, one larger tiled room is equipped for physical examinations and various treatment measures.

There are also administrative and social service offices. One section of the out-patient floor is designed for children. It is separated from the adult section and is directly connected by corridor with the pediatric department. A nursery school is equipped with a one-way observation screen. The dental department of the clinic adjoins the outpatient rooms, the department of physiotherapy is on the floor just below, and the diagnostic and treatment facilities of the clinic and of the New York Hospital are easily accessible.

The second floor of the clinic building is equipped throughout for laboratory work. Four rooms are used for photography and x-ray service. Nine rooms, on a sound protected subcorridor, are designed for psychologic research. The remaining twenty-five rooms on this floor are designed for chemical, physiologic, biologic, anatomic and other forms of scientific study.

Mechanical Features of the Building

For the teaching of students a lecture room with seating capacity of 130 is provided in the subbasement, but altogether above ground. Conference rooms of various sizes are also on the out-patient, main, third and fifth floors. Teaching of students is now principally with small groups, and accommodations for this have been provided throughout the clinic.

The clinic building receives steam and electric current from the central power plant of the group. A hot water heating system is employed, with a few supplementary steam radiators. Water is heated in boilers in the lowest basement of the building. For domestic and clinical purposes, hot water is circulated in two systems, in one of which

the temperature is much higher than in the other. Electricity is used for lighting, power, refrigeration and for clinical and scientific equipment. Provision is made for high and low potential currents, direct and alternating. A mechanical system of ventilation is employed, fans being placed in the lowest basement and in the roof structures. Electric refrigeration is used throughout, with ice water circulated to all floors. There are four elevators, two of which are operated by push buttons.

Cylinder locks are used throughout. All locks are operated by a grand master key, but there are seven separate systems, each of which is controlled by a different submaster key. Only authorized persons have access to the accommodations for patients and to the various departments. Keys differ sufficiently to prevent the key belonging to one system from entering any other lock. The telephone system is the dial type, connected with a central station for outside calls. A tapping system is used to signal physicians of the resident staff. Supplies of all kinds are obtained by requisition from the general stores or through the general purchasing department. The clinic has its own kitchen. Laundry work is done by the central laundry, though there is a supplementary laundry in the building. The entrance lobby, two reception rooms for patients, administrative offices, the record room, the medical library and a conference room are on the main floor. Two offices and a reception room are used by Bloomingdale Hospital, the long established psychiatric department of the New York Hospital, at White Plains. A few resident physicians have living quarters on this floor although the majority of the resident physicians are provided for in general staff quarters in the main hospital building.

County Hospital Superintendent's Salary Held Not Taxable

The Bureau of Internal Revenue was called on recently to determine whether the federal government could tax the salary of a physician superintendent of a county hospital in California. Under the constitution of the United States, the federal government may not tax the agencies by which the states discharge their strictly governmental functions.

The hospital involved was established under a California statute authorizing county boards of supervisors to provide for the care of the indigent sick. Another statute, the Pauper Act, places on every county the duty to relieve and support persons incapacitated by age, disease or accident, when such persons are not so aided by their relatives and friends, or by their own means or by state or private institutions. In this case the facilities of the county hospital are not available to anyone who can pay reasonable compensation for hospital care. The Bureau of Internal Revenue ruled that it is essentially a governmental function for

a state or its political subdivisions to take care of the indigent sick.

The county hospital consequently was held to be an instrumentality of the state engaged in the exercise of an essential governmental function and the salary of the superintendent was held not taxable under the income tax law. G. C. M. 10814 (C. B. XI-38-5698).

The bureau distinguished this case from an earlier one in which a different conclusion was reached. In the earlier case the hospital was operated by a county as "an ordinary hospital... where reasonable compensation was paid for care and treatment, although that hospital like all hospitals did have some charity patients." It was not operated exclusively for the benefit of the indigent sick and paupers. The salary of the medical director was therefore held to be taxable. When a state or county conducts a hospital in such a manner as to compete with the business of operating hospitals as carried on by private persons, that is, by taking all classes of patients regardless of their financial condition, the state or county will be regarded as performing a proprietary function. I. T. 2642 (C. B. XI-38-5697).

What of Vacations, Sick Leave and Professional Discounts?

By CHARLES E. FINDLAY

Superintendent, City Hospital, Springfield, Ohio

IN ORDER to learn the status of existing hospital practices with regard to vacations, sick leave and professional discounts, and at the same time to establish a basis for determining future activities, I recently completed a survey of Ohio institutions. Questionnaires dealing fully with these topics were mailed to members of the Ohio Hospital Association, from whose forty-six replies certain definite conclusions are evident.

Hospital authorities agree that vacations are desirable from the standpoint of the employee and of the institution, the usual vacation period with pay being two weeks. The majority of hospitals maintain a definite schedule of sick leave with pay.

Staff physicians, their families and graduate nurses who require hospitalization are given reasonable discounts and it is customary for staff physicians to treat hospital employees free of charge.

Let us consider first the timely subject of vacations. A vacation should be, as it is commonly defined, "a period of rest or leisure." During the past year hospital staffs have been faced with the difficulty of maintaining their institutions and continuing to give adequate and efficient service with limited funds. My opinion is that this summer more than ever these people will welcome a period of rest.

Practically all hospital executives replying to the questionnaire indicated their belief that vacations are desirable. This seems

to be the consensus of opinion among right thinking people today, whether laymen or professional men. It is recognized that vacation periods are desirable for students in public schools, colleges and universities. It seems right and just, therefore, that hospital workers, whose hours of duty are long and whose work is mentally and physically fatiguing, would profit by a reasonable vacation period.

Vacations should be planned in accordance with a definite vacation schedule. Every employee of the institution should be familiarized with this schedule at the time he assumes his duties. If an employee desires a longer vacation period than

From a survey of forty-six hospitals Mr. Findlay has drawn the following conclusions: Vacations are desirable from the standpoint of employees and of the institution; the usual vacation period with pay for employees is two weeks; a definite vacation schedule should be established for each position; employees who leave the service are not entitled to vacation allowances; they are not entitled to vacations with pay until one year's service is completed; they should not be forced to take vacations without pay; relief help must be employed in the majority of hospitals during vacation periods; hospitals as a rule maintain a definite schedule of sick leave with pay; it is customary to give a reasonable discount to staff physicians and their families and to graduate nurses of the school when they require hospitalization; staff physicians customarily render their services free to employees; employees are permitted as a rule to select their own physicians; hospitalized employees are generally classed as private patients and given private accommodations.

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that scheduled and his case requires special disposition, it should be considered from the standpoint of the individual case and on the basis of a leave of absence rather than an extended vacation period.

Hospital employees who have been in the service for some time often expect vacation allowances when they leave to accept other positions, to marry or for some other reason. It should be definitely understood that they are not entitled to vacations under such circumstances. A vacation is a rest before beginning a year's work, not a reward for past performance.

Forced Vacations Sometimes a Hardship

This survey of Ohio hospitals indicates that all employees who have rendered satisfactory service for a period of one year are entitled to vacations with pay. Some institutions may be forced to discontinue vacations with pay for the present, due to financial conditions, but there is no excuse whatsoever for not allowing vacations if employees are willing to take them without their customary compensation. Many hospital employees prefer not to take vacations if it means a loss in income. Many of them support families and the loss of one week's pay would be a distinct hardship. A forced vacation without pay in such a case would be advantageous neither to the employee nor to the institution.

Departmental heads should be permitted to attend important state and national conventions, the replies indicate. Such meetings may be considered periods of work and study, of recreation and play, of friendly contacts with professional and business colleagues. Time and money expended in attending conventions are generally insignificant as compared to the benefits derived by the institutions.

My survey reveals that the majority of hospitals find it necessary to employ relief in various departments during vacation periods. This situation is possibly more apparent today than in past years, due to the fact that the majority of hospitals are operating with a minimum of personnel. Any reduction in personnel for a period of time would consequently lower the efficiency of the institution.

Hospitals allow varying vacation periods for superintendents, department heads, supervising nurses, clerical workers and other employees. A list of typical hospital positions and the vacation period allowed for each by the majority of hospitals follows:

Superintendents, superintendents of nurses and assistant superintendents of nurses—one month; assistant superintendents, chief clerks, office employees, storekeepers, historians, instructors, supervisors, assistant supervisors, general duty nurses, orderlies, dietitians, chefs, housekeepers,

house mothers, social service workers, pathologists, roentgenologists, anesthetists, pharmacists, technicians, laundry foremen and chief engineers—two weeks; student nurses—three weeks; nurses' aids, power plant and maintenance employees and manual labor—one week.

My study shows that the majority of the fortysix hospitals maintain a definite schedule of sick leave with pay. It is further conceded by a number of hospital executives that a definite policy should be inaugurated granting to employees each year a certain number of days' sick leave with pay. Some authorities believe that the amount of sick leave with pay should be increased in proportion to the length of service of an employee and when this policy is in force the employee should be charged for hospital care and treated the same as any other patient.

I feel that such sick leave policies are poor psychology. It has been my experience that when certain employees learn they are entitled to a given number of days' sick leave with pay they invariably find it convenient to be sick for the stated period. Each case of absence from duty due to illness should be considered upon its own merits and the hospital superintendent should have full authority to determine whether or not the employee in question should receive compensation during the time of his absence from duty. It is my opinion that this procedure would greatly reduce the number of absences from duty due to illness.

What Free Hospitalization Costs

Hospital personnel receiving full maintenance should also receive hospital care. When these employes become ill, it is inconvenient to give them proper care in their rooms and they are forced to become patients in the hospital. If these employees were living at home members of their families would in many instances be able to give them the necessary care and there would be no need to admit them to the hospital.

My study shows that the cost of free hospitalization for sick employees and nurses in twenty-eight hospitals was \$48,753.56 for the year 1932, an average of \$1,741.20 per hospital. This figure, of course, would vary with the size of the hospital and the number of employees.

In considering professional discounts, first let us direct attention to the physician who is serving on the hospital staff. The medical profession, like the hospitals, has been called upon to give free service to persons who are unable to pay. Physicians give their services free to hospital employees and also give considerable time to the instruction of student nurses without compensation. They are also called upon to give unlimited service to indigent hospital patients, especially in municipal institutions, and they do it graciously.

For this reason hospitals feel called upon to give staff physicians reduced rates for hospital service when those physicians are in need of hospital care. There is some question in the minds of hospital administrators as to whether or not hospitals should render service to staff physicians and their families at a rate below cost to the hospital. My investigation indicates that opinion is divided in this. The discounts range from 100 per cent to zero.

Hospital administrators seem to agree that cour-

tesy discounts should be allowed to ministers, graduate nurses and members of boards of trustees, but that hospital service should not be rendered at less than cost. The study shows that the majority of hospitals do not allow discounts to families of physicians not on the staff, board of trustee members and married graduate nurses. A discount of 25 per cent is usually allowed to families of staff physicians and also to all the graduate nurses who received their training in the hospital's school.¹

¹Read at the meeting of the Ohio Hospital Association, Columbus, May 2-4.

Complete Giant X-Ray for Cancer Control in Chicago

Facilities for the control and treatment of cancer in Chicago have just been augmented by the completion at Mercy Hospital of an 800,000-volt x-ray machine and tube, which are said to be the most powerful ever put to practical use. Dedication of the new Institute of Radiation Therapy was attended by W. D. Coolidge, Schenectady, N. Y., the designer, and various local and visiting medical authorities.

Built to operate continuously at its conservatively rated capacity of 800,000 volts and 10 milliamperes, the apparatus exceeds by 100,000 volts the working voltage of any other installation known to be in regular operation. It has a current capacity twice as great as any other x-ray tube and machine in the world. The tube is fourteen feet long and is composed of two sections.

Radiation from the apparatus, it is estimated, will be equal in quantity to the radiation from \$75,000,000 worth of radium at current prices for radium salts. The installation places Chicago in a leading position as a world center for the study and treatment of cancer.

Forty Tons of Lead in Walls

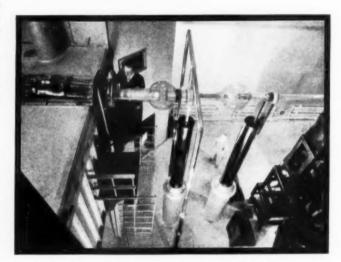
A special building has been constructed to house the new machine and tube and other x-ray apparatus in use at the institution. The building is 62 feet long, 32 feet wide and 36 feet high. More than forty tons of lead were used in the walls and floors of the building for protection against the cumulative effects of x-rays upon those who are working in the laboratories constantly. Automatic safety devices are prominent throughout the installation. Twenty-two tons of lead line the walls of the white tiled chamber where the patient receives the rays. If the door is accidentally opened while the machine is in use the current is automatically shut off. The current is also automatically shut off if the door to the high voltage room is open.

On a narrow bed, the patient is wheeled into the x-ray chamber and placed where the rays from the tube will reach the part to be treated. Rubber and metal lined blankets protect the rest of the body. The operator, at a switchboard outside, surveys the patient through a periscope and also converses with him as the predetermined dosage is being administered. A special device immediately in front of the operator measures the dosage, thus ensuring a constant check while treatment is under way.

Dr. Henry Schmitz, director of the institute, and a pioneer in radiation therapy in this country, has estimated that of the 300,000 people in the United States who have

some form of cancer, about 90,000 each year need some form of radiation, either radium or x-ray. In his opinion, the x-ray is the economic solution of the treatment of large, massive and deep-seated cancers.

"Radium radiations lose rapidly in intensity as the distance between the radium and the body is increased because the radiations are diffused in the air," Doctor Schmitz explained in comparing radium with x-ray treatment. "With the x-ray tube, however, the initial intensity is great, and loss by diffusion is relatively slight. The direction of the rays from their source may be controlled by using long distances between the tube and the patient, and a series of beams directed diagonally toward the tumor. Thus by a summation of the energy of several successive



A view of the x-ray tube from the observation balcony. The generating apparatus is at the right. At the left, the x-rays are directed at right angles into the treatment room.

beams, the dose in the tumor surpasses the dose received on any area of the skin surface.

"It would require 100 radium treatment institutions, each with twelve grams of radium, located in the principal population centers of the country, effectively to handle 90,000 patients. Since this would require far more radium than is available in the world today, the economic solution is the establishment of 100 institutions equipped with high power x-ray equipment equivalent to that installed at the Mercy Hospital Institute. Furthermore, the cost of this x-ray equipment would be only about one-sixth the cost of radium equipment. Yet the same number of patients could be cared for."

The Hospital and the Medical Staff*

The Pathologic Conference Should Be an Open Forum

By GILBERT DALLDORF, M.D.

Pathologist, and

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THE necropsy is a benison to the medical staff, to the hospital and to future patients. It confirms correct deductions and diagnoses; it reveals mistakes; it helps to prevent future mistakes; it constantly reminds the physician of the basic structural changes in disease; it settles clinical arguments with certainty; it accepts no invalid excuse for inferior clinical work.

The medical profession and the hospitals tacitly acknowledge the importance of the necropsy in their zeal to increase necropsy percentages. But neither files of protocols nor impressive percentages are sufficient. It may interest and educate the pathologists themselves to have frequent access to morbid anatomical material, but the postmortem has failed to perform its function unless it has taught its lesson to the clinician as well. Knowledge gained at the necropsy table must be communicated to the medical staff. This is readily done through some form of a clinico-pathologic conference. Such a conference, properly attended and conducted, can bring to the doctor, to the hospital and to the future patient, the fruits of this important instruction.

Conferences of this type are regularly conducted in many hospitals—in some of them with great success. Certain hospitals in this country and abroad have had famous conferences, high lights in the professional life of their communities. Professor Schmorl of Dresden, who recently died, for many years conducted pathologic conferences of such excellence that they were attended by physicians from far distant points.

The too frequent practice in such conferences is to recite the clinical features of each case and

then to demonstrate the morbid changes, usually with a discussion limited largely to an exposition by the pathologist. This is inadequate. The clinicopathologic conference should be an open forum where conclusions are commonly reached to problems presented by fatal cases, and by living patients from whom surgically removed pathologic material is available. The background of the problem may be revealed in a succinct pointed summary of the medical record which should be as brief as possible. This summary should not seek to describe every detail of the clinical and other observations made during life; it should rather identify the case as to age and sex and describe the general features of the malady encountered by the clinicians, its progress, and the type of treatment.

The Best Way to Show Necropsy Material

Following this, the organs may be demonstrated and the lesions briefly described. The method for exhibiting this pathologic material will have direct bearing upon the realization of the purpose of the conference. Specimens should be arranged to show the lesions which have been found. The usual method is to place them upon trays for this purpose. If such a method is employed, it is best not to pass these trays about, but to place them, under excellent light, upon a long table accessible from both sides, with members of the pathology staff present to explain them. A still better method of showing necropsy material is through the superior devices now available for projecting images of objects upon a screen. These projectors will throw upon a screen the image of an organ, enlarged from five to ten times its actual size, in the actual colors of the specimen. The pathologist at the projecting machine can demonstrate lesions with a rubber gloved hand. He can, by handling the specimen,

^{*}This is one of a series of discussions for the purpose of ensuring better team work in the hospital through a fuller understanding of the interrelated problems of the medical staff and the administration. The first of the series appeared in the January issue.

give a clear indication of its consistency and other properties.

If, in combination with such a projector, there is a shadow box for exhibiting x-ray films, and if the projector, as is possible, is also used to throw upon the screen pages from the clinical record, the demonstration becomes particularly complete and clear. Proper demonstration of material cannot fail to stimulate questions and discussions. The clinicians, having actually grasped the significance of the conditions the pathologist has demonstrated, will not permit the meeting to remain merely a pathologist's monologue.

Conference Requires Careful Preparation

Bacteriologic, chemical, and histologic evidence may need to be admitted to reach the diagnosis. The underlying principle, in fact, of such conferences should be that they represent a time and a place where all the existing information bearing upon the case can be weighed and a full report reached.

In most necropsied cases the pathologist's findings are clear and definite enough to establish the nature of the disease process, but in other cases other facts may be conclusive. A paroxysmal fibrillation can be attested only by the clinician. Sometimes evidence in the past medical history may be impressive enough to modify the interpretation of the abnormal conditions found at necropsy. The clinico-pathologic conference is a court in which all pertinent evidence may be admitted and where the verdict may be based upon a full review of the evidence, uninfluenced by preconceived opinion.

It is important for the pathologist and his staff to assume an unfixed attitude towards the clinical evidence. Only by such an attitude will that full discussion occur which brings home to the doctors the real value of the cases. The pathologist should of course have the right to state his final opinion because frequently he alone will be able to weigh the significance of the changes observed.

The clinico-pathologic conference should pursue a fair but unbiased policy in the interpretation of clinical errors. It should determine whether the error was due to mistaken interpretation of physical signs, to a carelessly taken history or to failure to utilize all of the resources of the institution. The conference must be equally fair in pointing out the inevitability of error when such is the case. From such a plan of action there will quickly grow in the staff a firsthand knowledge of the diseases that can be diagnosed and those that cannot, and a knowledge of the conditions in which definite evidence can be collected and those in which only presumptive evidence is obtainable.

A conference requires careful preparation. The

clinical record should be intelligently abstracted to include the significant features. The anatomic specimens should be dissected to show clearly the changes that are important. A high degree of imagination is necessary for this. The specimens should be arranged to attract the spectators' attention to the matter of import. Sometimes the inclusion of a normal structure will serve to emphasize the morbid change.

In most hospitals the largest regular attendance at pathologic conferences comes from the house staff. Certain of these men will have little future opportunity to observe their cases at necropsy. For their benefit and for the records of the hospital, it is well to have the proceedings of the meetings recorded and mimeographed, copies to be provided for those who attend, and copies to be filed upon the clinical record and in the laboratory. A full volume of the proceedings could fittingly be bound and kept in the medical library.

While these conferences are of undoubted value to the resident staff, they by no means serve their proper function unless they are well attended by members of the visiting staff. These men will find the conferences of valuable assistance in sharpening their medical wits and in keeping their knowledge up-to-date. The presence of "visitings" always contributes to the earnestness of such meetings, and any worth while visiting physician can be expected to be particularly interested in the necropsy findings of the cases of his service.

Meetings Should Be Informal

A clinico-pathologic conference is no place for "high hat" manners. When discussion is slow it is wise to poll the members and ask for individual declarations of opinion. The less informal the meeting, the more beneficial it will be. Conferences should be held regularly and not too often; probably every second week is best. Organs cannot be kept in fresh condition much longer than this, and the cases tend to become "cold" and less interesting.

While the clinico-pathologic conference belongs to the pathology department of the hospital more than to any other, it is believed that the chairman of the conference may well be the clinical director or the chief of staff. This is desirable because of the fact that the pathologist himself is too busy with his demonstrations and discussions to give thought to conducting the meeting, and because, perhaps, a "referee" may sometimes be needed to give equal opportunity to the clinical and pathologic sides in the discussions. The chairman, whoever he may be, should be alive to the functions and importance of the conference, and should do his utmost to promote informative discussion.



Latest Equipment, Efficient Layout Feature Chicago Hospital

By JANET PETERKIN

Associate Editor, THE MODERN HOSPITAL, Chicago

THE department of obstetrics and gynecology of the University of Chicago is housed in the Chicago Lying-in Hospital, the unit farthest west on the campus and a fitting counterpart to the university chapel at the east end of the group.

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> Beauty of exterior and interior design characterizes the building, which embodies the most advanced scientific and mechanical equipment. A striking architectural feature is the Janet Ayer Fairbank cloister which extends across the south side of the building on the Midway. It bears on its arches eight escutcheons on which are carved the names of seven outstanding contributors to the science and art of obstetrics. One escutcheon is blank. It is reserved for the inscription of the name of the man who shall discover the cause of eclampsia.

> The institution is composed of two structures without any direct interior connection except by conduits and pipes. Its main building, the clean maternity, has six floors and a basement, with accommodations for 141 mothers and about 150 babies. The smaller building, the Mothers' Aid Pavilion, is the isolation unit. It has three stories

and a basement and can accommodate twenty-two adult patients and sixteen infants. Connected with this building is the school, which provides for the teaching and research activities of the department of obstetrics and gynecology.

The main entrance to the hospital leads into a small and dignified reception hall, and facing the doorway and brightening the oak walls is a decorative mosaic panel in gold and rich colors. A fine portrait of Dr. Joseph B. De Lee, the founder of the hospital, is hung in this vestibule.

The lines of traffic have been carefully planned to ensure a certain privacy to women arriving in labor and to bring them quickly under the care of the receiving nurse, without exposure to the ordinary business traffic of the hospital lobby. Administrative offices are on the first floor on the left, and on the right are admission and clinic services. A group of social service rooms are near the admitting room.

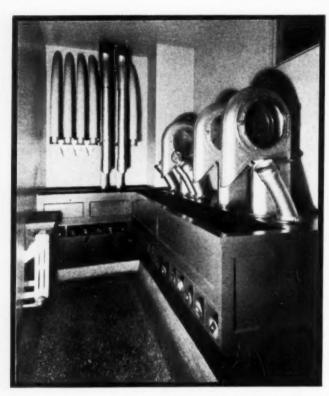
The large general waiting room is attractive in its appointments and has an air of restfulness and comfort. Walls are oak paneled and the floor is of dark terrazzo. The furniture is upholstered in red

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A pneumatic tube system is provided for transferring histories, messages and drugs from floor to floor.

leather. Over the mantel is a large oak frame divided into twelve sections, representing the twelve months of the year. In each section is space to inscribe one name for each day of the particular month. It has been estimated that if enough contributors can be found each willing to endow a day by donating \$2,000, an income of \$100 a day will be forthcoming to help defray the cost of extending the free and part-pay service. The names of these donors will be inscribed on this calendar opposite the day they have endowed and this will form a perpetual record.

A gift shop is an unusual feature on the first floor. When mothers register a note is sent to them telling them about the shop, where they may buy layettes and other baby clothes. Lingerie, toilet articles and novelties are displayed here in glass and chromium show cases and the shop maintains a gift service for candy, flowers and books, taking orders and working through the downtown stores. There is also a lending library in connection with the shop, for patients' use. Profits are used to help finance the Mothers' Aid Pavilion.

The work of sterilizing dressings, with the exception of those for the birth rooms and the isolation unit, is carried on in the general sterilizing and supply room on the first floor. All solutions for intravenous injections are prepared here. Dressings are made by the members of the Mothers' Aid Club in a large room assigned for this purpose in

the Mothers' Aid Pavilion. They are packed in the general supply room and complete sterile sets are made up in bundles ready for use.

The x-ray department has been placed on the first floor at the east end of the building.

Practically the entire south wing of the first floor is devoted to clinic patients and the examining and treatment facilities are unusually complete. In the large waiting room the walls are covered with an oak wood veneer, an effective treatment for a room of this type. This material is used also on the pillar effects and arches in the corridor, as well as on the walls of the doctors' conference room on the fifth floor. It is applied like wall paper and is ironed on with a hot iron.

Ten examining rooms, each with two dressing rooms, provide for a rapid succession of patients and the individual privacy of each. Prenatal and postnatal clinic patients are examined here. The examining rooms are arranged in standard fashion. In the prenatal examining room a three-panel screen, on casters, is placed around the head of the examining table, the side wings of which run very easily and do not get in the doctor's way. Paper towels are used on the pillow and at the foot of the table so that it is only necessary to replace the linen once a day. There is a chromium plated gooseneck spotlight and on the wall, in addition to an ordinary timepiece, is a clock which ticks every ten seconds so that the doctor may count the heart tones of the unborn infant and take the maternal pulse without glancing at a watch. A similar clock is placed in every examining room, every first aid room and every labor and birth room. A wall type of manometer is also found in the examining room.

Every Ward Has a Utility Room

At the hand scrub sink the faucets are operated by a foot pedal as is the built-in soap dispenser. The lid of the waste receptacle is also raised by a foot pedal. There is an additional handy waste basin which runs on casters and which the doctor can keep beside him. It is surrounded by a circular rubber bumper so that it cannot harm the equipment or the wall as it is pushed about.

In the clinic workroom are two horizontal water sterilizers, one for hot water and one for cold, also one dressing and one instrument sterilizer.

A room on this floor is set aside for teaching prospective mothers. There is also a room for basal metabolism and one for prenatal dental care.

The second, third and fourth floors are the patients' floors. On the second floor are two services, one the usual maternity, with a nursery, and the other, the prenatal department. Patients suffering from heart disease, nephritis and other medical and noninfectious surgical complications occupy

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one wing on this floor. The workrooms and adjoining ten beds on the northeast wing are intended for the use of unmarried mothers. There is a considerable area of roof promenade on this floor over the first story portion of the dispensary. Every ward has its own utility room, with an outside window.

The third floor is the main maternity section for free and part-pay patients, in two-bed and four-bed wards. The babies have two spacious nurseries, each with a large bathroom and dressing room adjoining. There is also an isolation or observation nursery with four marble and glass cubicles. Babies suspected of even the mildest infections are put in individual cubicles and observed. If the infection becomes pronounced the infant is immediately transferred to the Mothers' Aid Pavilion where it is given a little room to itself. The nursery windows have ultraviolet ray transmitting glass.

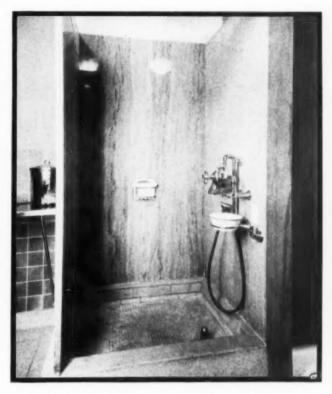
Blue and Rose Color Scheme for Private Rooms

Each floor has an observation room, well isolated, for a possibly infected mother, although the usual practice is to send such cases to the Mothers' Aid Pavilion at once.

A large room for special treatments is also on each floor, to be used on occasions for teaching students and nurses in small groups or for talks and demonstrations to mothers. A clinical laboratory on each floor enables the interns and students to make the simpler laboratory tests without delay.

The fourth floor is devoted exclusively to private rooms, each of which has a private toilet and many of which have a private shower. A typical room has wood furniture, maple or walnut, of modern design, and the general color scheme is rose and pale blue. Rose leather cloth is used for the upholstery and the window draperies are blue, or vice versa. This leather cloth may be washed with an antiseptic solution. The rug is rose taupe. There is a dresser, with a separate mirror, an easy chair and stool and two straight chairs, a bedside table and a screen. The rooms are lighted entirely by lamps; there are no wall or ceiling light fixtures. Two lamps are on the dresser, one is at the bedside and there is one floor lamp. The night light is placed low on the wall opposite the door and is turned on by a switch in the corridor as the nurse enters. The doors are 4 feet wide and have hinged sections top and bottom which serve as ventilators. Night lights are placed low on either side of the corridors so that patients are not disturbed by them even if their ventilators are open.

The toilet rooms have attractive pale blue or pink tile walls and are completely equipped as service rooms for the patients. A distinctive and practical feature is the nurses' marble worktable with noncorrosive metal shelves below for storing



An innovation is the preparation shower in the birth department, which replaces the preparation slab.

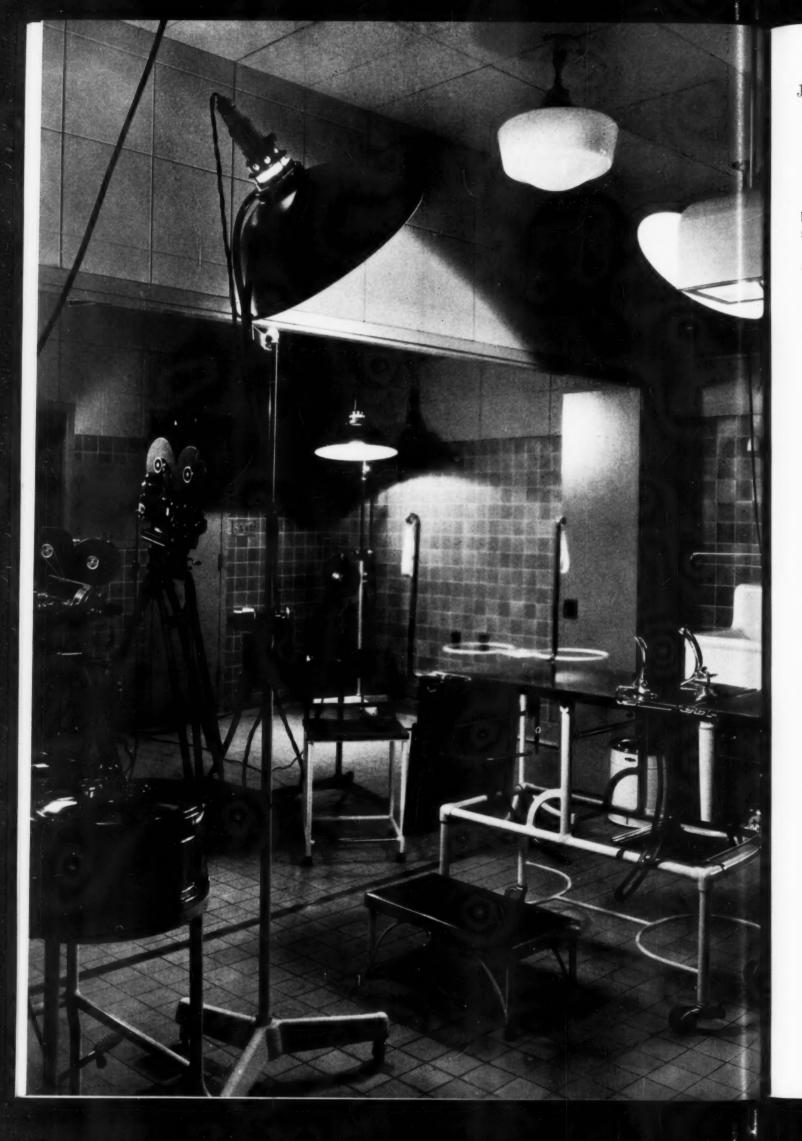
everything that the patient may need. Above is an electric connection for sterilizer installation or other heat using equipment. Each patient has her own bedpan which is sterilized twice a day. The water closet is equipped to serve also as a bedpan cleansing sink.

There is one nursery on this floor; with twentyeight bassinets. Wire basket cribs are used, in individual stands. Each crib has a thermometer holder attached so that each baby has an individual thermometer. Each baby is allotted twenty cubic feet of space. Nobel boxes are used for premature babies instead of incubators, or if a baby needs a little extra heat it is put in the box instead of having a hot water bottle.

In the babies' bathroom there is a refrigerator for storing the supplementary feedings. Sterile drinking water is piped to each nursery.

The nurses' station is large and completely equipped. It has an outside window. Along one wall is a shelf for writing histories, and there is a portable history cabinet, on casters, and two desks. The medicine closet is in a light place near the window. Inside it is a small narcotic cabinet, the key of which is entrusted to the nurse in charge. When the door of the narcotic cabinet is open a soft buzzer rings until it is closed again. There is a tiny sink in the medicine closet for washing medicine glasses.

The isolation nursery on this floor is used for



There is a completely equipped utility room between each two birth rooms in the institution.

babies awaiting a diagnosis because they are running a temperature or show certain symptoms indicative of infection. It has three marble cubicles, with glass between.

On this floor is also a special nurses' rest room.

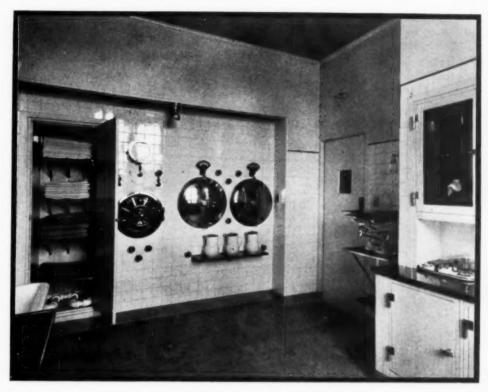
A notable innovation at this hospital is the service corridor found on each of the patients' floors. Here are placed all the working and utility branches of the floor. The serving pantry, the utility room, the steriliz-

ing room, the janitor's closet, the linen room, the flower room, the clothes chute and the nurses' toilet open from this corridor. There is also a special feature here in the built-in brick lined recess for two large waste cans. Above the door of this recess is an intriguing small door that serves a happy purpose. The nurse when she has paper or garbage to dispose of, simply opens the small door and thrusts the waste into one of two metal funnels, which ensures the safe passage of the waste directly into the waste cans. Thus is avoided unsightly litter on the floor or untidy bits overhanging the edge of the can. This device originated at the Lying-in Hospital.

The use of the service corridor reduces traffic and confusion in the main corridor. It is equally accessible to each wing of the T-shaped structure and is used for practically every purpose but not by visitors, all of whom use the main corridor. Two of the three elevators discharge into the service corridor. The third which is solely for visitors discharges directly in front of the nurses' station and

opposite a small visitors' waiting alcove.

Patients' food is brought to the serving pantry from the main kitchen in electrically heated carts, by way of the freight elevator. There are no dumbwaiters in this hospital. Only coffee and toast are made in the pantry. All dishes are washed before



they are returned to the kitchen. The china and silverware used on the patients' trays are of attractive color and design. Special mention may be made of the dainty little sugarbowl, which has two compartments. Granulated sugar is placed in the bottom of the bowl and this is covered by a tiny tray on which is placed the loaf sugar, a clever arrangement for eliminating an extra sugarbowl and conserving space on the tray.

Birth Rooms Are Completely Equipped

The flower room has tile wainscoting and an acid resisting sink. The drainboard is large and there is a shelf for arranging flowers. Quantities of papier-mâché unbreakable flower containers of varied sizes and shapes are stored on a high shelf.

A day's supply of linen is kept in the floor linen room and the floor supervisor sends her requisition every morning to the central linen room in the basement.

The fifth floor is the birth room floor and it can care for 4,000 deliveries a year. There are four birth rooms, a large amphitheater and a combination moving picture studio and birth room. They are grouped in the north wing. All labor rooms, of which there are nine, are for one patient only. They are grouped in the south wing. Between the two and in the east wing are the necessary adjuncts. There are two fully equipped preparation rooms and also a small kitchen on this floor.

The birth rooms are somewhat larger than the usual operating room and are provided with all the paraphernalia that the most exacting surgical tech-

One of the birth rooms is equipped with all the facilities necessary for the taking of talking motion pictures, which is a new departure in hospital planning. The equipment is stored behind the folding doors,

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nique could demand. Tiles of a soft shade of green are used for the wainscoting and the walls are painted green. On a bronze plaque in each room are inscribed two Latin mottoes: *Primum non nocere!* and *Non Vi Sed Arte!* Each birth room has a viewing gallery for twelve spectators.

The equipment in these rooms is standard. There is a little table for forceps deliveries and a special heavy obstetrician's chair. A portable manometer on a stand which runs on casters is used for taking the blood pressure of the patient on the table. The birth room crib is provided with everything for taking care of the baby—silver nitrate for the eyes, a thermometer, sterile albolene for oiling the baby, tags for marking the back, and clothing for the baby, who is dressed right in the crib and goes forth to the nursery like a little citizen.

Amphitheater Seats Eighty-Five Persons

Entrance to the amphitheater is from the sixth floor which obviates the need for students entering the birth room floor. This entrance is in addition to the entrance from the fifth floor and the service corridor. It seats eighty-five persons and has a balcony encircling three sides of the pit. A rather wide wind shield of shatterproof glass keeps the spectators entirely remote from the sterile field and keeps dust from falling on it. Spectators at operations are required to wear masks. A group of nineteen ceiling lights illumines the operating field. Thus the view of observers is not obstructed by portable lamps arranged around the table. Instead of standard switches the lights have mercury

nonsparking switches to eliminate the hazard of explosions from the use of ethylene.

In the workroom for the amphitheater are two 200-gallon capacity water sterilizers, one for hot water and one for cold. These have no water glass but have a water gauge. This is probably the first time that sterilizers of this type have been installed in a hospital.

Motion Picture Studio Is a New Departure

Adequate provision has been made to produce motion pictures, now considered so important in the teaching of medicine. A motion picture studio is a new departure in a hospital and at the Chicago Lying-in one of the birth rooms is equipped with all the wiring equipment and other facilities necessary for the taking of motion pictures. There are electric plugs scattered over the ceiling so that the lights may be placed most advantageously. Here it will be possible to film unusual vaginal deliveries and abdominal operations. This room constitutes an important teaching unit. A dark room opens off this combination birth room and moving picture studio.

The nurses' workroom is centrally placed and fully equipped. The pass-through type of sterilizer is installed and drums are packed in one room and taken out in the next.

The rest of this floor is devoted to observers' room, the fathers' room, study and conference rooms for doctors and students, a laboratory, dressing rooms for men and women doctors and living quarters for the resident doctors.

In the doctors' conference room informal clinical lectures are given by the attending staff and others after interesting cases have been delivered. In this room a green glass bulletin board is used to record the condition of patients in labor. As an intern completes his examination he posts his report on this board where attending men can check up on their cases. There are spaces on the board for entering the patient's



The amphitheater workroom contains two 200-gallon water sterilizers. These have no water glass, but have a water gauge. . 6

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name, the time of her entry to labor room, the number of the labor room, the service she is on and various scientific facts about the condition of the patient, and a space is left for general remarks.

A reference library opens off the conference room.

The sixth floor is given over to living quarters for the personnel. There are twenty-eight interns' rooms. In the men interns' wing the lounge is comfortable and colorful in its treatment and a tresses go in one room and come out in the other) and unusually generous space for general storage.

The Mothers' Aid Pavilion is the architecturally isolated building for infectious cases, built apart from the hospital proper in accordance with the principle that such cases in the interests of safety for others should be isolated both architecturally and administratively.

In this building each woman has her own room, and each baby has a little room with an outside



The large general waiting room is attractive in its appointments and has an air of restfulness,

balcony opens off it which runs the whole length of the building. In the women interns' lounge the color scheme is attractively worked out in gray and yellow, with a dark blue rug. A kitchenette opens off the lounge and also a large balcony. Leather cloth upholstery is used in these rooms. The superintendent has a homelike suite, attractively fitted out, on this floor.

In the basement are the laundry, the linen rooms, the kitchen, the dietitian's office, the babies' milk kitchen, the housekeeper's office, adequate locker rooms and toilet facilities for the various classes of help, the carpenter shop, the paint shop, the pharmacy, mattress sterilizing rooms (matwindow and door, a table for its bath and other necessary equipment. On one floor access to the rooms may be had from a balcony, this arrangement being made for the handling of particularly contagious cases. The toilet rooms are even larger than those in the main hospital and in each is a laundry tub where linen is soaked in 5 per cent antiseptic solution before being sent to the laundry. Sterilizing and utility rooms are provided in profusion and there are incinerators on each floor and in the operating suite for the immediate destruction of infectious material. In the service pantry is a sterilizer for sterilizing dishes before they are sent to the kitchen.

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On a smaller scale, a service lobby is provided for the serving pantry and for the utility and sterilizing rooms of this building. In convenient places in all the corridors are scrub-up sinks for the doctors and students.

The birth room is large and light. There is a labor room in conjunction, which can be used as a clean delivery room if the first is infected. On the first floor is a little operating room, for opening abscesses and for the minor infectious surgical work.

Pavilion Has Own Laundry and Kitchen

Sun parlors and open air balconies make it possible to give outdoor treatment to both mothers and babies. The sun parlor on the third floor is a cheerful spot, the furniture being of the latest modern style. Pencil blue leather cloth is used for the upholstery and contrasts effectively with the black tables and bright metal frames of the chairs. The windows are shaded by Venetian blinds of the newer type. These blinds run in metal slots, an arrangement that keeps them always in line.

The Pavilion has its own laundry, its own kitchen and its own linen room in the basement.

Teaching facilities are housed on the first and second floors of a building juxtaposed to the Mothers' Aid Pavilion and communicating with it and in close connection with the main hospital. On the second floor of the school section are several laboratories and a classroom. On the first floor the outstanding feature is the Dora De Lee Hall, equipped by Dr. Joseph B. De Lee in memory of his mother. This oak paneled lecture hall seats about 140 persons. It is fitted with motion picture projectors and with talkie apparatus.

The rest of this floor is taken up by the administrative offices and the reception room and other general facilities.

A large room is assigned to the Mothers' Aid Society whose members make the dressings for the hospital, as well as baby clothes and binders. Often as many as 11,000 obstetrical pads are made daily.

The hospital buildings are liberally protected against noise, soundproof material having been used on the ceilings of all corridors, birth rooms, labor rooms, nurseries, the laundry, the kitchens and the lecture hall.

A pneumatic tube system is provided for transferring histories, messages and drugs from floor to floor. Some of the containers have fur lining so that bottles may be carried safely.

Elevators are self-operated and are of the selective, collective automatic control type, with car leveling devices. If the elevator is moving upward it stops at all floors to pick up calls going upward, and vice versa. An emergency key is provided so

that an elevator may be called to the floor to take care of an emergency patient regardless of all other calls.

At intervals in all corridors are recessed drinking fountains of black porcelain, with a side bubbler of the new sanitary type with angle stream, which prevents contaminated water falling back upon the supply jet. There is also a faucet for filling pitchers with ice water.

Doctors' scrub-up sinks are in alcoves in convenient places in all corridors, so that they may scrub completely before and after visiting each patient.

Artificial ventilation has been limited to what the law demands and natural ventilation substituted when possible.

An interesting feature is the preparation shower in the birth department, which replaces the preparation slab. The patient is bathed standing up, and further necessary preparations are made on a table. These showers have standing wastes which permit about three inches of water to remain on the floor of the shower room.

Since high pressure steam is supplied by the university, there are no boiler rooms but there is a large machine room in the basement of the Mothers' Aid Pavilion.

Innumerable built-in metal cupboards lighten the tasks and add to the efficiency of all workers. These are found in practically every room and are painted to match the walls.

Low Cost Services Available

A large sheet of noncorrosive metal protects the outside of doors from damage by cots or other furniture which may be carelessly pushed through by orderlies or others. It covers approximately the lower third of the door.

Provision for radio entertainment is made throughout the hospital. In the wards, head phones are used and in the private rooms, patients may have loud speakers or head phones as they prefer. A charge of ten cents a day is made for head phones and one dollar for loud speakers.

In this hospital a mother unable to pay more may have a baby at a cost of only \$55 for a normal confinement and ten days' care in a four-bed ward. If she is unable to pay this sum she may have a further reduction or may be given free service. Semiprivate and private rooms are available for those who are able to pay the necessary cost.

To Jessie F. Christie, who recently resigned from the superintendency of the hospital after seventeen years of service, much credit is due for the efficient planning and arrangement of the hospital.

The architects for the hospital were Schmidt, Garden and Erikson, Chicago.

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The Medical Structure—Government, Hospital and Physician

By N. W. FAXON, M.D.

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"Be not the first by whom the new is tried, Nor yet the last to lay the old aside."

THIS motto might well be adopted by the hospital administrator. Progress is change, adaptability. The hospital that remains static is not progressive. Economic crises, either up or down, hasten changes, stimulate self-analysis, intensify old problems and produce new ones. The hospital administrator's duty during the past three years, even more than in other years, has been to study keenly the problems presented and to evolve satisfactory and progressive solutions.

The past influences the present. At first there were only patients. Then there were patients and physicians. Patients tended to congregate. Charitably-minded governors, religious orders and individuals provided places for their care, and hospitals appeared. These hospitals cared for the homeless sick, for pilgrims, for wanderers. Those who had homes stayed in them when they were sick. Physicians then found they could care for these patients more easily and satisfactorily in

hospitals. Anesthesia, asepsis and nursing fitted hospitals especially to care for persons suffering with serious illnesses. Hospitals then expanded to admit all classesthe poor, the middle class and the wealthy.

Let us now examine the present medical structure and restate the relationships of patient, physician, hospital and state. All medical and hospital activities may be divided into governmental activities and nongovernmental activities. Governmental activities embrace (1) public health services of federal, state and municipal governments and (2) federal, state, county and municipal hospitals. Nongovernmental activities embrace

(1) private physicians and (2) private, charitable and proprietary hospitals. I deliberately place private physicians as the first of nongovernmental medical activities. In our concentration on distinctly hospital problems we frequently forget the importance of the private physician in institutions, although the foundation of medicine and all medical activities rests upon him.

Our present medical structure embraces three general classes of activities: (1) activities accepted as the responsibility of government, whether federal, state or municipal; (2) activities accepted as the responsibility of private charity, either through individual units or by community chests and other means; and (3) activities accepted as the responsibility of the physician.

Under the first group of government activities, let us list sanitation, control of communicable diseases, partial care of the indigent sick and care of those patients suffering with long term diseases -mental illness, tuberculosis and chronic ailments. Care of the chronic sick is only partly

borne by this group of govern-

ment activities.

Under the second group of private charity activities come partial care of the indigent sick, partial care of chronic sick and care of part-pay and private patients.

Under the third group of physician activities we find care of the sick everywhere, whether in salary, whether paid or unpaid, whether treated at home, in the hospital or in the out-patient de-

partment.

Such in general is the present medical structure. Certain problems need clarification. For instance, what is the limitation, if any, of governmental responsibility? What is the relationship and what should

Doctor Faxon, addressing the joint meeting of the Illinois, Indiana and Wisconsin Hospital Associations in Chicago, reviewed graphically the development of the present medical structure, enunciated the present policy of relationships between patient, physician, hospital and government and suggested plans for the future including prepayment of hospital charges and hospital and community councils.

be the relationship between physician and hospital? What is the relationship of patient to government, to hospital and to physician?

Governmental responsibility has increased for a hundred years. During the past thirty years it has increased rapidly. Should it stop? Will it stop? Many persons believe state medicine to be logically correct. Practically it is undesirable because it prevents free choice and initiative. Medicine has been and will be personal and individual. State medicine cannot be personal and individual.

Physician and Hospital Must Cooperate

Straws show which way the wind blows. The Economy Bill eliminates the care of veterans with nonservice connected disabilities in government hospitals and prohibits the building of nongovernmental hospitals. This is the first retrograde movement in the previous expansion policy. It is the first set-back to pension legislation in the United States. If this be a criterion, government responsibility will maintain its present status for a while at least.

As to the relationship between physician and hospital, it should be cooperative and complementary. Each needs the other. Hospitals cannot exist without doctors and doctors cannot properly practice medicine without hospitals. A great deal is said about competition. Doctors complain that they are forced to compete in private practice with hospitals and that such competition is unfair. Does such competition exist? In a way, yes, but essentially, no. The hospital has its own particular sphere and the physician has his.

Open or Closed Staff, or Both?

Physicians should care for a high percentage of illness which needs only watching, diagnosis and direction. Some persons place the figure at 80 per cent. Hospitals should care for selected cases, selected mainly by physicians. Physicians can and should care for cases of illness in homes. Hospitals should care for persons who cannot receive care at home either because of the nature of the illness or because of the home condition.

The question of open *vs.* closed staff has been and will continue to be much discussed. An open staff undoubtedly lifts the general level of medical practice, while a closed staff improves the quality of hospital care. Which will benefit the community most in the long run is an old and open question. It is probably desirable to have both, according to local conditions.

Let us now consider the relationship of the patient to the government, to the hospital and to the physician. The medical structure, which includes the physician, the hospital and the government, is

operated on the policy "that no person shall be unable to obtain proper medical and hospital care, regardless of financial condition, but that no one shall receive such care at governmental or charitable expense who can afford to pay for it."

The government, the hospital and the physician are all prepared to supply medical care without cost in cases where it is necessary. The policy of medicine has always been to adjust charges according to the ability of the patient to pay. This is a just policy but difficult to apply because of dishonesty in some instances. Nevertheless, no better policy has been proposed. Other policies, though they may not have similar defects, have other defects that seem more undesirable.

In general, then, we care for the indigent sick without charge. We care for the part-pay sick, accepting, as physician or hospital, what they can pay. We expect those who can afford to do so to pay in full both the physician and the hospital.

Financing Hospitals

Let us consider, at this point, some special problems of the present and future. How shall hospitals be financed? Let us think of the future rather than of the immediate economic crisis, which hospitals must meet in their own way.

Government hospitals will be financed by taxation, of course, but it is now apparent that even these must be limited to real needs. Extravagances cannot be borne indefinitely by governments any more than by individuals.

Private charitable hospitals will be financed as in the past by receipts and by gifts. These gifts will continue. The charitable impulses of five thousand years will not cease because of the present economic depression. There is some question, however, as to whether they will continue to flow as abundantly as they have during the past thirty years. Consequently some other means of financing hospitals must be found.

Government Funds and Private Hospitals

The most promising of all methods yet suggested is that of periodic payment by groups to provide for hospital charges; in other words, insurance against sickness, necessitating hospital care. This seems the soundest way. It promotes independence in the individual, it is American and it does not disturb medical relationships. It will release funds from gifts for the care of part-pay and free patients. Workmen's compensation cases, founded upon this same principle, have pointed the way. No one who can recall the hardships borne by individual workmen and by hospitals before the advent of workmen's compensation would ever wish to return to the arrangement then in force.

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Another policy has been receiving increased acceptance lately—the payment of funds by governmental units to private hospitals for the care of indigent patients in private hospitals. There are few arguments against this policy and many arguments in favor of it, and in general it seems to be a common sense method of making the most of community facilities.

A third progressive step toward the improvement of community health conditions will be the formation of some coordinating mechanism to consider and direct all measures coming under this head. Hospital or health or community councils must be established if we are to plan wisely and well. Hospital councils may well form the first step toward the formation of the more inclusive health council. Voluntary and organized hospital councils exist in many communities. These may easily be expanded into community councils. The objects of such councils will be: (1) to consider the needs of community health, (2) to plan according to community needs, (3) to conserve community resources and (4) to control community expenses for health measures in order that all persons interested in such matters may have a voice in their deliberation. Such councils should be composed of representatives from hospitals, medical societies, health bureaus and welfare organizations, as recommended by the Council on Community Relations and Administrative Practice, A.H.A.

How to Prepare the Heating Plant for the Summer Shutdown

The heating plant is a highly important as well as an expensive unit in the hospital's equipment. Every care should be taken to keep the heating plant in firstclass shape and to protect it from damage. This will pay dividends in the end. The heating plant can be damaged during the summer months when it is not in operation just as well as during the period of operation in the winter. In fact, damage incurred by heating boilers during the summer months is often more serious than that received during the winter season.

Corrosion resulting from the combination of moisture in the cellar air and sulphur in the soot, ash and residue, the sulphur being introduced originally as a constituent of the fuel, is the principal cause of damage to the boiler during the summer. Corrosion reduces the useful life of the boiler and makes necessary a replacement sooner than should be necessary. Proper care of the heating plant will eliminate this hazard.

To eliminate this corrosive action during the summer months when the boiler is idle, *Domestic Engineering* suggests the following precautions should be taken at the end of the heating season:

1. Soot, ash and residue should be completely removed from all heating surfaces. Boilers usually are provided with flue cleanout openings through which the heating surface can be reached by means of brushes or scrapers. If the boiler is of steel construction, the heating surfaces, after cleaning, can be given a coating of lubricating oil on the fire side. This will tend to prevent corrosion, and will burn off quickly when the boiler is placed in service again.

Where machined surfaces are open to corrosion, they should be coated with oil or grease.

3. Perhaps the most noticeable evidence of corrosion of a boiler may be found in the smoke pipe connections from the boiler to the chimney, especially when the cellar air is damp. If too frequent replacement of the smoke pipe is found necessary, it is advisable to make a regular practice of cleaning out all soot and ash from its interior, and in the case of small boilers, the pipe should be placed for the summer in a dry place after cleaning. In case galvanized material is not used for the smoke pipe, it is good practice to paint the outside as an extra precaution.

4. Where considerable moisture exists in the boiler room,

the boiler may be drained to prevent atmospheric condensation on the heating surfaces when the temperature of the latter becomes lower than the dew point of the surrounding air. This involves the hazard, however, of someone inadvertently building a fire in a dry boiler, which would ruin it. For this reason, it is safer to keep a boiler filled with water. It is advisable to drain all water and sediment from the boiler, thoroughly rinse out with clear water, then refill to a point where the water just enters the steam main, and leave in this condition while shut down during the summer. A hot water system usually is left filled to the expansion tank.

5. Clinkers, cinders and ashes should be removed from the firepot, grates and ashpit. At this time, an inspection of the grates can be made advantageously to determine whether they are in firstclass shape. Broken or badly warped grates may be responsible for wasting fuel by permitting unburned or only partly burned fuel to pass into the ashpit for disposal.

6. The outer surfaces of the boiler should be cleaned, removing soot, ash and residue. Remove any rust or other deposit by scraping with a wire brush or sandpaper. After the boiler is thoroughly cleaned, apply a coat of preservative paint where required to parts normally painted. While these items are matters of appearance largely, they are important in maintaining the effectiveness of the whole installation.

To prevent corrosion during the summer, it also is advisable to oil the door hinges, damper bearings and regulator parts.

College Credits Required in Some Schools

In an effort to turn out better qualified nurses and at the same time to limit the size of their classes, owing to the economic situation in nursing, many of the better schools of nursing have raised their entrance requirements to include one year of college prenursing work.

Other schools that have not actually written such a requirement into their catalogues are selecting college women in their classes, many of them with degrees in science or arts. Ninety per cent of all students in accredited schools of nursing are now high school graduates, according to the Grading Committee.

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Remedying Justifiable Complaints of Patients

NE wongers what is done about patients' complaints in hospitals and if anything comes of the various suggestions and criticisms when they are actually received. Recently THE MODERN HOSPITAL decided that the subject was worthy of some study and accordingly secured from a large New York hospital information as to how it handles complaints.

The hospital which has furnished the information for this article has for some years sent to all discharged patients a questionnaire containing six questions and one blank for suggestions. The returns vary between 20 and 25 per cent and it is therefore reasonable to assume that no complaint of service was found among 75 per cent of the discharged patients and in addition only about half of the 25 per cent that answered made any complaint. Few hospitals could show as good a record.

As is common in all hospitals the major complaint was against the food and the food service. Out of eleven specimen questionnaires five of the patients complained about the food and food service, several of them mentioning specifically poor coffee. Two of the eleven complained of the nursing service while the other nine praised it very highly. Two other complaints related to the charges, and were based upon misunderstandings.

Noise and Poor Food-Constant Complaints

In making a study of complaints from discharged patients consideration should be given to the nature of their illness. For instance we find this complaint from a woman in the maternity ward:

"Was disturbed by loud talking and laughing of visitors to other patients. Suggest some means of reducing the noise in corridors as the noise seems to be extra loud as heard by patients. Too many visitors are allowed to congregate in the corridors and talk and laugh."

A colitis patient offers these comments:

"Food was cold by the time it reached me. Was distressed over lack of silverware. One spoon was sent for cereal, fruit and egg. Annoyed by banging of doors to toilet and utility rooms which were opposite my room. Also heard the banging of pails and the splashing of water. Was charged extra for medicine and sun ray treatments. Was

not consulted as to whether or not I could afford these treatments."

An appendicitis patient says:

"Was annoyed by moaning and coughing of other patients when door was open."

A nurse who had graduated from the hospital and who was an acutely ill medical patient said she was disturbed by the noise of garbage cans and by the banging of utility room doors.

A female fracture case sent in the following: "Consider food poor. On one occasion had tainted beef. Disturbed by sick child in next room crying at night. Annoyed by open water pitcher which seems unhygienic. Suggest water bottle."

"The Coffee Was Poor"

A woman suffering from sinusitis said she considered the head day nurse inefficient and lacking in tact. She also complained that she could not get orange juice at night, that the coffee was poor and there was a lack of silver and linen.

A male bronchitis patient complained of the poor coffee and the thin milk.

Not all of these complaints, of course, are well founded but many of them are. For instance, the head day nurse in this particular institution is most efficient and the complaint must be attributed largely to the condition of the patient.

However, most of these complaints are such that with but little trouble correction could be made and a more satisfactory service rendered the patients. There is little excuse for poor coffee and so many mentioned this trouble that the importance of correcting it is apparent. Lack of silver was mentioned also and it is so easy to remedy this matter that the complaint should never be heard again.

The elimination of noise, both the banging doors and the talkative visitors can be corrected, the first much more easily than the second. However, visitors can be made to understand that they cannot disturb patients and with proper supervision on the part of the floor nurse this annoyance can be curbed if not wholly eliminated.

It can be readily seen that with the complaints about the food service and the noise eliminated the already high percentage of satisfied patients could be raised in this model institution.

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A Hospital Housekeeper Must Know Her Work and Her Workers

Good hospital housekeeping cannot be reduced to a formula. Needs of institutions vary widely and the housekeeping department must be flexible enough to dovetail with or overlap every other department. To keep the buildings economically clean with the least possible interference with continuous use of rooms is the housekeeper's primary duty.

By DORIS L. DUNGAN

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THE hospital housekeeper's work falls naturally into four general classifications: general maintenance, linen room and laundry work, personnel procedures and research work. Under general maintenance comes the care of walls, floors, woodwork, windows, lights, radiators and metals. It was formerly a hard and fast rule that floors of a mineral base must be scrubbed and floors of a linoleum base must not be scrubbed. The present trend is to seal all surfaces and cut scrubbing to a minimum.

Wood floors, once most difficult to keep in condition, are now things of beauty. A new filler which penetrates the wood to the depth of one-eighth inch has been tested in the halls of Columbia University where six thousand students pass daily. After three years the floor is still in good condition. Water wax used over this filler will make upkeep less difficult.

How to Treat Linoleum and Cork Tile Floors

Rubber floors will last the lifetime of the building if they are cared for properly. Since air and oil are natural enemies of rubber, floors of this material must be sealed from the air. Soaps and ordinary waxes cannot be used since their solvents are also solvents for rubber. To eliminate the danger from oils it is best to refrain from using soaps of any kind, oiled dust mops or sweeping compounds. Water waxes may be had that fill the pores of the rubber and give a resilient finish which need be renewed only twice a year.

Linoleum and cork tile floors can be finished with a liquid preparation combining varnish and wax. By actual test this material will wear three times as long as floor wax. In connection with waxed floors, it is well to remember that no dust will arise when sweeping. Friction causes the waxed surface to become negatively charged, while dirt, which is composed of carbon and silicates, is electrically positive. Dust is therefore pulled down to the waxed surface.

Care Is Necessary in Cleaning Marble

Composition floors should be maintained with a neutral linseed oil potash soap and there are commercial fillers and sealers for these floors.

Terrazzo, tile and marble floors may also be sealed. Tile and terrazzo are not injured by scrubbing but this method of upkeep is expensive. This is the polishing era and the scrubbing brush is out of date. Marble is crystalline limestone and cleaners containing alkali should be avoided. Cleaners known as salts, such as tri-sodium phosphate and sodium carbonate and bicarbonate, will penetrate marble and form in the pores as the marble dries. As the process is repeated these deposits grow in size and exert considerable pressure within the marble. A solution of soft water and neutral potash vegetable oil soap should be used to clean marble. Javelle water, ammonia water or a detergent will remove stains from marble. Acid actually dissolves marble and must be avoided.

Concrete floors are now made with the color mixed in at an additional cost of only two cents a square foot. Or a one-inch top layer of colored cement can be laid over an old floor. Cement floors can also be sealed.

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Walls collect dust, soot and smoke which combine with moisture from the atmosphere to make an oily film. Remembering that oil is the medium which holds paint to the wall, we must avoid cleaning with strong alkalis which dissolve oil. Nonsudding compounds are less apt to streak walls than are soapy ones. Walls should be washed starting at the bottom to prevent streaking. Water trickling over a dirty surface leaves streaks because dirt comes off unevenly due to uneven soaking. Clean surfaces do not streak. Brushing walls from the bottom up is best since dirt clings to walls at a downward angle of 45 degrees. Brushing up lifts it off; brushing down smears it in.

Linen Room Problems

Now comes the study of cleaning compounds and detergents—soaps, scouring preparations, paint and floor cleaners, bleaches, silver and metal polishes. All white bar soaps contain water glass or sodium silicate which keeps the soap hard and brittle. The advantage of bar soap over powder is that it is not so easy to use too much.

The quality of abrasive used is the important consideration in scouring agents. The amount of soap, soda and abrasive should be determined, as well as the tendency to scratch polished surfaces.

Polishes which contain acids will attack silver and nickel. Litmus paper will show the presence of acid. Lemon oil should always be used for bronze. It is also a good furniture polish.

Linen room and laundry problems involve a study of the care and selection of fabrics. Linens used in a hospital are selected first of all for wearing qualities. Sheets with equal hems top and bottom last longer because they are reversible. The thread count should be evenly balanced. An average count is 72-74 warp and 64-68 filling. A good grade sheet will weigh about twenty ounces. Count glasses may be had in different sizes. Some are ruled to make counting easier.

Pillow cases should be larger than the pillows. Cases made of tubing are best since the seam end can be opened and the edges changed. The crease should not be brought entirely to the center of the case.

Bath towels are made of plain and ribbed terry. A fairly loose weave is absorbent and easily laundered. The count glass will show whether or not the pile loop is made with a double thread. Bath towels should weigh about seven pounds per dozen.

Face towels may be either crash or huck weave. They may be cotton or union towels. The linen in a union towel makes it wash easily since linen releases dirt more easily than does cotton. Face towels should weigh about three pounds per dozen.

Blankets should be carefully chosen. For hos-

pital purposes a cotton warp blanket is more serviceable than one made on a wool warp. There are one-third more warp ends in a cotton warp, which means that the filling is tied in much more closely. A good half cotton and half wool blanket will outwear any number of cheap wool blankets which may contain shoddy or reworked material. A whipped edge is more serviceable than a ribbon binding and will last the lifetime of the blanket.

Wool content may be tested by boiling a sample of the blanket for ten minutes in a solution of lye and water. The alkali will destroy wool and leave cotton. Sheets may be tested for sizing by putting enough iodine in water to make a pink solution and dipping a sample of the material in it. If heavily sized, the sample turns black.

In table linen the housekeeper should be able to tell the difference between cotton and linen fibers. Cotton is a short flat tube with a slight twist. Linen is straight and stiff but shows tiny knotlike lumps which mark areas of cell growth. If rough dark spots or lumps show when the sample is held to the light, the yarns are not of the first quality. These spots are called slubs. Linen weaves are known as single and double damask. Double damask does not mean double strength but indicates the type of loom on which the linen was woven. In double damask only every eighth thread is bound down. Unless a double damask cloth counts 195 threads to the inch, it is safer to choose one made of single damask.

Efficient Laundry Will Save Money

Methods of linen control must be worked out to fit the individual linen room system. Presbyterian Hospital, New York City, has a director of linen control and laundering and a system of ordering by symbols. Permanent stains from certain medicines were reduced by making nonstaining solutions standard so far as possible and issuing solutions such as iodine only in the quantity immediately needed. A perpetual inventory system will help in keeping a check on linen and in reordering. Undying fame awaits the person who finds a method to stop the hiding of linen in dressers and lockers, thus keeping it out of circulation and increasing the amount necessary to maintain service.

The laundry is no longer a necessary nuisance. It can and should be not only a convenience and a money saver but also a good will builder for the institution. Most people do not realize that technical knowledge is necessary to wash clothes properly and that actual money is lost when that knowledge is lacking. Even at current prices it costs \$3.40 to dress a bed without a blanket. At least \$2.50 worth of bedding is washed daily. Counting 300 working days in the laundry, there is an in-

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vestment of \$75,000 from 100 patients' beds. Add to this figure the gowns, towels, pads, operating room linen, uniforms and nurses' home linen which the laundry handles and the figure is more than \$100,000. If lack of knowledge in your laundry is causing even 1 per cent loss of tensile strength, a loss of a thousand dollars is occurring yearly.

Regular Work Schedules Are Important

The housekeeper must know the chemical analysis of products she uses and must see that the washman knows their proper use. Formulas should be posted in plain sight and adhered to strictly. If the temperature is dropped between the suds and the first rinse the suds will break down and deposit the dirt again on the clothes. All solutions should be added as the wheel is going down. The load is then at the back of the washer and the solution mixes with the water before touching the clothes. The housekeeper needs to know vegetable, cotton, linen, animal, wool, silk and rayon materials. She must recognize organic, inorganic and vegetable stains and know their methods of removal by solvents, absorbents, detergents and bleaches. Studies in nine Philadelphia hospital laundries show a laundering cost of between four and five cents per one thousand pieces.

In her eagerness to do her work well the housekeeper is apt to forget that she is dealing not only with things but with people. She must explain carefully and patiently to her assistants what is to be done and then she must see that they do it.

Regularity of work is important and schedules for each worker should be posted in the service closets. This does away with the excuses, "I didn't understand" or "I didn't know it was my work." Schedules must sometimes stretch a bit here and there. Accurate check on work may be kept by giving each cleaner a book and pencil of his own. He notes each day's work in the book and turns it in to the housekeeper each day.

Another method is to post a form headed like this:

Room No.—Walls—Windows—Floors—Doors—Lights—Radiators. Each worker fills in opposite his name the work he has done that day. This form will also help the housekeeper to keep her cleaning record up to date. Even in small hospitals meetings help to increase interest and pride among the workers and to give them the sense of working with the housekeeper instead of for her.

The worker should be physically able to do the work required. He must be mentally able to use and care for the tools needed in his work. He should be told exactly what is required in the way of hours, amount and appearance of work and what he may expect as to wages, time off, sick leave

or promotion. A study of psychology will enable the housekeeper to place the workers to the best advantage.

The housekeeper must study herself more carefully than she studies her employees if she is to get the best results. Does she really like people? If not, they will not respond to her. She must be confident and sure of herself to instill confidence in others. Good health is a great advantage, as well as good personal appearance. The housekeeper should be calm and poised. She must be able to think things through, plan her work and work her plan. She should be enthusiastic about her work so that employees will enjoy working with her. She should give credit where it is due and learn to see the funny side of her work. Her people should know that what she says one day will apply the next and that they can depend on her to stand back of them so long as they do their work well.

To be able to classify people is helpful. Persons whose interests turn in to themselves are called introverts; those whose interests turn out are extroverts. Most persons are mixtures. Introverts are more careful of other people's possessions than are extroverts. Introverts are good writers, extroverts good talkers. Introverts like to argue and do not take orders easily. Women are more inclined to be introverts than are men. Men dislike explanations. Women are apt to take criticism personally. To become emotionally involved in this way is to lose time and energy.

The Housekeeper's Qualifications

The ability to judge people according to introvert and extrovert characteristics is helpful to the housekeeper in gauging the approach to each type. The skillful and successful housekeeper does not treat all people alike. She treats them in the way they like to be treated and thus gets the response she wants and the cooperation she needs with the least effort and friction. Knowledge of psychology helps the housekeeper to develop the knack of getting the best work from each employee and of getting and giving the utmost cooperation in dealing with fellow executives. It helps her to foresee results of her own actions and to gauge her actions to bring responses that promote harmony.

To summarize, the housekeeper must be tactful, approachable and cooperative. She must analyze herself, see the environment she is creating and develop the ability to work with others. She must get the other person's viewpoint of her ideas and not be too sure that she is absolutely right. She should remember that she is training others and must think and plan toward the future.

³Read at the meeting of the Hospital Association of Pennsylvania, Philadelphia, March 21-23.

Big Hospital Fire Reveals Need for Fireproof Construction

By

GEORGE W. BOOTH

Chief Engineer, National Board of Fire Underwriters, New York City

THE value of fireproof construction and the hazards of frame construction were emphasized in no uncertain manner by the fire which destroyed a considerable portion of the main group of buildings comprising the Robert Packer Hospital, Sayre, Pa., on May 3.

The fire was discovered about 8:20 p.m., during visiting hours. The fact that the 223 patients confined to the institution were removed without loss of life is proof of the efficiency of the hospital's organization. Doctors, nurses, interns and orderlies were immediately busy and in less than five minutes after the fire was discovered all patients had been removed from the private floor and the men's ward, which were in immediate danger. Patients in the other sections were then removed. Ambulances and private automobiles were pressed into service to take the patients to other hospitals and to private homes.

In the absence of a detailed report on the occurrence the complete story cannot be told, but certain facts in connection with it are so outstanding as to be worthy of serious thought and study by hospital managements the country over.

The Fire Spread Rapidly

The Robert Packer Hospital consists of a four-story and basement fireproof clinic; a main building or group of mainly frame construction, two stories in height, but with three fireproof portions fairly well cut off and occupied as an operating department, wards and private rooms. A joisted brick kitchen adjoins and communicates with the main building or group. The other buildings of the hospital are well detached and were not involved by the fire.

The various frame units of the main group adjoined and communicated so that a continuous fire area of approximately 28,000 square feet was formed and as the results showed was subject to a single fire.

The first indication of fire was smoke coming

through the floor from the basement in the men's surgical ward, a one-story unit of the frame portion of the main group. The origin of the fire has not been learned. The telephone was the only means available for transmitting the alarm, but a public fire station with motor equipment was within easy reach.

Apparently the fire spread rapidly and owing to the highly combustible nature of the construction, the long flue-like corridors and the absence of substantial cut-offs, the major portion of the frame portion of the main group was quickly involved. Handicapped as it must have been under such conditions, it is remarkable that the fire department was able to save any part of the frame buildings. It is also fortunate, but likewise remarkable, that there was not serious loss of life and personal injuries. This is indeed something to be thankful for. It seems probable that this good fortune may be attributed to the low heights of the buildings involved, the cool heads of the management and the good work of the fire fighting forces.

That the fire did not penetrate to the interior of the fireproof buildings of the main group is unquestionably due to the protection in the way of fire doors provided at communications.

An Oft Repeated Lesson

Every one who has given the matter any thought knows that frame construction has no place in buildings of hospital occupancy. This fact has been stressed frequently by the National Board of Fire Underwriters and THE MODERN HOSPITAL in connection with the service program which they rendered to the hospitals throughout the country but a short time ago. The hospital reports of the stock fire insurance organizations have also emphasized this whenever occasion afforded an opportunity.

It is well to ponder what might have happened if the management had not used the best of judgment in evacuating the buildings involved; if the public fire department had not been readily available.

The lessons of this fire are the oft repeated ones of what to expect where combustible construction, large areas, absence of fire walls and lack of provisions for the automatic detection and extinguishment of fires in their incipiency obtain. A few good fire walls and the provision of automatic sprinklers would have removed the possibility of a fire of such extent. Indeed it is highly probable that with such means present the fire would have been extinguished in its incipiency. This occurrence again unmistakably points to the desirability of fireproof construction for buildings of hospital or institutional occupancy.

Must We Sacrifice Nursing Education to Nursing Service?

By EFFIE J. TAYLOR, R.N.

Professor of Nursing, Yale University School of Nursing, New Haven, Conn.

THE nursing profession is enmeshed in bewilderment and it is essential that we analyze and endeavor to separate the factors of the relationships involved both in nursing education and nursing service, so that we may arrive at an objective truth, uncomplicated by personal wishes. Without this truth we cannot hope to clear our vision and cure the profession of its ills.

When studies are made in an attempt to satisfy a community demand that obvious errors and practices be rectified, boards of trustees, committees and commissions often admit publicly that certain undesirable and unhappy conditions exist. They frequently add, however, that these conditions must be tolerated because change would be difficult and would involve reconstruction of policy and expenditure of money.

This method of disposing of the findings of a study may satisfy the conscience of administrative authorities, but it does not remove the evils and usually tends to increase dissatisfaction and discontent and gradually breaks down confidence and sympathy between the groups concerned in the controversy. Development of cooperative plans for participating in necessary adjustments is prohibited by such procedure, and unnecessarily arbitrary measures are often resorted to by the oppressed in order to obtain the right to survive and the possibility to progress in the future. Studies undertaken on a scientific basis where facts and figures have been published should result in attacking difficulties in a more constructive way.

Looking to the Future

In considering the problems of nursing education and nursing service, the Committee on the Grading of Nursing Schools has shown us exactly where we stand. It has denounced in no uncertain terms the system which for the past forty years has kept the profession sick and has placed it in its present state of chaos with hundreds of nurses out of employment, charges upon the profession and upon society. The committee has presented data to show why many nurses are not only out of employment but are unemployable and has sug-

gested that we take stock of its pronouncements and reconstruct present policies.

There are members in the nursing profession whose vision is far clearer than that of others, and many of those who follow are endeavoring to catch a glimpse of what they see. It is only by so doing that progress is made in any field of activity. In nursing we are obligated, for the sake of both the present and the future, to change our traditional points of view and look beyond the present if we are to offer more than a group of panaceas for present ills.

Apprenticeship System at Fault

The majority of difficulties in nursing before us today are inherent in the system of education and apprenticeship service, although many of the problems, because of the world economic situation, are shared in common with other professions.

About a decade ago M. Adelaide Nutting, in an address entitled "Twenty Years of Nursing in Teachers College," spoke of the shortage of public school teachers as well as the shortage of nurses. It is interesting to note that the remedy advocated at that time by educators in both these fields of professional work was not the creation of numbers but the selection of more highly qualified candidates. Miss Nutting said:

"I perceive that notwithstanding the shortage of teachers, of doctors in rural districts and of many other useful workers, the remedy does not seem to lie in hasty creation of vast numbers of workers of inferior education and general equipment, but rather in an opposing effort to hold up good requirements for entrance, to improve constantly methods of training and conditions of work and make that branch of human activity a desirable and happy one to enter."

Until recent years the cry of "shortage of nurses" was constantly heard. As directors of nursing services as well as educators, we were forced to put forth our best efforts to encourage young women to enter nursing schools which during the last decade were increased each year by hundreds in order to meet the urgent needs of

hospital nursing services for the care of patients. As a profession, therefore, we are not without a certain responsibility for the present oversupply of nurses although the primary responsibility does not rightly belong to nursing.

The fault lay in the system, which provided that nursing service of hospitals be maintained on an apprenticeship basis, and, because of the demand for numbers, the admonition of Miss Nutting and others to make quality of applicants a more important factor than quantity was not heeded. Today we are face to face with an emergency which must be met and must be prevented from recurring.

School or Service?

Nursing education and nursing service are, in their fundamental objectives, two entirely different projects, but they have many interrelations. Our problem has become difficult because the patient—to serve whom is the objective in the training of both doctors and nurses—is found in the hospital ward and here his care is provided through medical and nursing service.

In contrast to medical training, nursing is still suffering from the handicap of paying for its education in hours of work and service and from endeavoring to make these hours of work and service replace hours of supervision and instruction. Preparation of students for nursing in most schools is largely a training through chance experience rather than through conscious education.

Education of the student for her vocation should be the first objective of any professional school. The service she may give should be incidental to her education. The fundamental objective of the hospital nursing service is daily and immediate care of patients, with all other functions secondary to this primary one. There is a distinct difference between the primary functions of a school and of a service. In each case when the school and service are combined the primary function becomes the secondary and each becomes a means to an end.

But the primary function of the school of nursing is inevitably evaded in the hospital. When the school of nursing is charged with the nursing service, care of the patient becomes its primary function and its resources are used for that purpose. Therefore, since the chief resources of the school are its students, the first use of students under existing circumstances will be for care of patients.

The question arises as to the right of the hospital to conduct a school when it does not, and usually cannot, provide for the legitimate function of a school. Learning by the apprenticeship method, in former times and in other vocations, did not necessarily imply the objectives of a school and did not assume its obligations.

Apprenticeship is a method of training for an occupation by which one party already master of the occupation imparts to the other his knowledge and skill in return for service or labor. The amount of instruction a student receives under this system depends largely on ability of the master to teach, number of students to be taught and time at the disposal of each group. Even the apprenticeship system is exploited in nursing schools, since the major time of the student is spent in service with the minimum of supervision and instruction.

Blanche Pfefferkorn, director, department of studies, National League of Nursing Education, recently made a study of student activities on twenty-two open wards in ten different hospitals.1 The study was confined to an observation period of one day of ten hours (600 minutes) on each ward and included medical, surgical and pediatric services. The average time given directly to bedside instruction was found to be approximately 15 minutes per ten-hour day, and the average time of direct supervision was 11 minutes per ten-hour day, a total average of 36 minutes out of 600 minutes which could be recorded as teaching. The figures ranged from 0 to 115 minutes of instruction and 0 to 94 minutes of supervision. In two wards during an entire day no time was recorded for teaching, and in fifteen wards less than 20 minutes of the total 600 was recorded for teaching. The maximum amount of supervision recorded was 94 minutes. In thirteen wards no time was recorded for supervision, and in eighteen the supervision amounted to less than 20 minutes.

Too Many Nonnursing Duties

Another study tabulating domestic or nonnursing duties for both graduate staff and student nurses presents a remarkable and significant picture. The minimum amount of time spent by graduates in nonnursing activities was 2 per cent of the total time and by student nurses, 3 per cent; but the maximum amount of time spent by graduates in nonnursing activities was 13 per cent and by students, 67 per cent.

It is obvious that when graduate nursing service is provided, maid and helper service is also provided; but where student service is depended upon the subsidiary staff is correspondingly smaller. It is possible that 2 to 3 per cent of subsidiary or nonnursing duties may be essential to the comfort and safety of the patient, but an assignment of nonnursing duties above a possible 10 per cent is an unwarranted use of students' time. Such use of students' time is open to question even from an economic standpoint.

¹Pfefferkorn, B., What Do Student Nurses Do? American Journal of Nursing, Jan., 1933, pp. 55-66.

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Figures from the grading committee uphold the statement that neither formal nor informal bedside instruction of student nurses is adequate to justify the use of the term "school" as applied to most schools of nursing. The reason is obvious when we find that the average or typical school out of a total of 1,146 reporting has an approximate daily average of 191 patients, with 56 student nurses, $4\frac{1}{2}$ head nurses, $2\frac{1}{2}$ supervisors and $1\frac{1}{2}$ instructors.

Must Consider Quality of Students

Even on the apprenticeship basis this teaching and supervisory staff is exceedingly small, and one cannot but wonder that hospitals have been willing for so long a time to accept responsibility for a nursing service which, under the conditions revealed through statistical studies, must inevitably be inadequate. Very young student nurses, inadequately taught and supervised, are carrying a great responsibility. It is appalling to review the statistics on nursing at night and to realize the paucity of the nursing staffs in most hospitals. And yet we congratulate ourselves on providing good nursing service to patients. In reality, in the majority of hospitals neither the nursing school nor the nursing service is wholly adequate.

We are told that there is an oversupply of nurses. We believe this to be true. If, however, hospitals throughout the land were sufficiently staffed, the majority of able and employable nurses would be holding positions.

An adequate permanent staff is essential to the comfort and well-being of patients, and the community or state must find the way to make this service available without the organization of too many schools—schools which continue to produce innumerable poorly trained nurses to become a drug on the market after three years of hospital service. With the present surplus of graduate nurses, it is an economic waste to staff hospitals with new, inexperienced student workers, many of whom will be out of a job when they graduate.

The nursing profession is criticized by its own members, by hospitals and by the medical profession for many of the evils of the present situation. Nurses are no longer willing to stand aside and accept this criticism without using their influence to urge the cooperation of nurses, hospitals and physicians in finding another way to care for patients without leaning so inordinately upon the nursing schools.

The nursing service should give adequate nursing and safe care to the patient. Quality of students should be considered more important than quantity, and schools of nursing should be organized so that their primary function is education.

If this were the policy, there would be no conflict between nursing service and nursing education. Nursing education cannot be divorced from service to the patient any more than medical education or social education can be estranged from their objectives. Emphasis on education will automatically produce the best possible care of the patient. But emphasis on most economical care for the greatest number of patients does not always operate for the best interests of nursing education.

Service to the institution, to which we have referred, is something quite different, and this analytical difference must be clearly understood before we can intelligently make the distinction between nursing service and nursing education.

Most activities in which nursing students are engaged should be learned and practiced at the bedside of the patient. They should, however, be practiced under skilled supervision and direction until they can be carried on with ease and with perfect safety to the patient. If teaching and learning conditions are on an educational level, the majority of nursing procedures can be learned in a much shorter time than is generally acknowledged; they will take a much longer time if they are left to the usual current trial and error method.

The educational factor depends less on the number of activities engaged in than on how well these activities are performed, how clearly the student understands the principles involved and how they are applied.

Budgets vs. Ideal Nursing Education

The ideal concept of education in nursing is based on a new kind of teaching to ensure more intelligent performance. Hospital nursing service may signify a high type of care to patients or it may signify a variety of service to the hospital which enables the institution to function more economically as a whole. Here lie some of the fine points of distinction in defining nursing service.

A difficult problem faces those who are struggling on the one hand with hospital budgets and deficits, and on the other with ideals for nursing education which, if put into practice, will add to the deficits. Intelligent thought, however, dictates the making of two separate issues of these widely different but related problems, and the tabulating under separate headings of factors entering into each. So far as I know, this subject has never been thoroughly and scientifically analyzed in any school or hospital. A few valuable studies in accounting have been made but these do not offer much help.

In presenting some basic relationships and basic differences between nursing education and nursing service, I have endeavored to emphasize the advisability of cooperative study between the groups

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using the service and those contributing the service, for the ultimate benefit of those dependent upon nursing. Collective thinking brought to bear upon a subject involving many groups has distinct and significant values, since no welfare worker can successfully function apart from his co-workers and collaborators.

Educators in the field of nursing carry a grave responsibility, not only because of the complicated problems involved in nursing education for the fulfillment of its relationships, but because of the traditional handicaps under which it has labored during its existence. There are two distinct phases of this subject and a point of departure where specific professional responsibility must supersede collective responsibility and must therefore assume the initiative. This initiative deals with the school of nursing and the education of student nurses.

Nursing Schools as Separate Units

Probably no one would question the right of the professions of law, medicine, theology and engineering to determine policies and a curriculum for students in preparation for these professions. The same is true of the professions of teaching, social service, nutrition and domestic science.

Specialists in various fields of teaching are essential on every faculty. It is understood that in nursing schools specialists from other faculties must be called upon to participate in giving instruction. Because of their special experience and knowledge members of other faculties will assist in formulating policies of nursing education and in building up curricula. There is no disagreement on the wisdom of basing educational policies and programs on analyses of functions of the professional workers in each of the separate fields. In nursing schools, however, the content of nursing education is largely based upon the functions in one field—the hospital.

Education in professional or vocational schools should have as its primary objective the preparation of the student to function acceptably in the field of life. The more definitely and coordinately vocational education can be allied to life in its actual setting, the more effective it will be. Therefore, policies of nursing education and the curriculum in the school of nursing should be built not only upon what nurses are required to do in the institution but upon what they are called upon to do in life outside the institution.

The first requirement in developing intelligent policies is a complete job analysis of nursing functions. The collaboration of hospitals, administrators, physicians and the community is essential in a program of study involving so many groups.

Nurses understand the fundamentals of nursing

better than any other body of workers and the major responsibility for the program of education for students in nursing schools should logically be left in their hands. Schools of nursing must inevitably be organized as separate units, whether in hospitals or in other educational institutions, in order that their objective may be safeguarded and their education not be made secondary to service to the hospital.

We have been accustomed to think about these controversial questions from three angles only—the hospital and nursing service, the student and the nursing school and the doctor and the medical service. We have forgotten the community and the state as factors greater than all others and the real root of all the difficulty. It is the failure of state and community to provide adequately for medical and nursing care which has forced the hospitals to resort to measures of expediency and to retain obsolete systems. The school of nursing provided a means by which the hospital could meet its obligation.

Education for nursing has been an excuse for the hospital and the system in practice has been an easy financial escape for the student. Nursing education cannot be obtained without cost and a part of this cost at least the student herself must pay. Obviously the hospital cannot supply both maintenance and education without receiving scmething in return. But education and service are incompatible when jobs are the first essential, when the conservation of time is the greatest factor and when quantity of achievement supersedes quality in procedure.

Fundamental Changes Must Come

Service is primarily concerned with immediate and present situations within the institution, while vocational education is concerned with fitting the student for professional activity. What the next step should be is somewhat uncertain, but it is reasonably safe to assume that fundamental changes must take place. This assumption is based on knowledge of the historical background, of statistical studies on the present situation and of certain definite trends toward future demands in nursing. We know that the condition of nursing today is unsatisfactory and it would be unintelligent and shortsighted to perpetuate a system no longer producing satisfactory results.

We have struggled for many years with certain fixed ideas which now appear to be delusions. That they have served an end no one will deny. But with new insight we must attempt to make obvious adjustments, difficult and personally disturbing as they may be.¹

¹Read before the American Conference on Hospital Service, Chicago.

How Hospitals Are Weathering the Economic Crisis

By CAROLYN E. DAVIS

Superintendent, Good Samaritan Hospital, Portland, Ore.

HOSPITAL administrators today must maintain and even improve the quality of hospital service and still make ends meet. An ever increasing demand from the community for free or part-pay service, with decreased income from the higher priced accommodations which have been the financial backbone of the unendowed hospital, creates a unique situation for the present day administrator to meet.

An Encouraging Prospect

The greatest advances often have been made in times of stress. Calamities frequently unlock doors opening into new worlds of power and happiness. Hospitals, beyond a doubt, not only will find a way to meet present economic conditions, but in the solution will emerge greatly enriched. One encouraging prospect for the future of voluntary hospitals is the fact that their boards of trustees, and in many instances their communities, are taking more interest than ever before in hospitals. So long as the monthly balance sheet remained in the black, or showed a slight margin of profit, all was well, but a red balance sheet month after month has caused much concern and has stimulated a healthy interest as to the cause. Trustees are, for the first time in many years, really interested in individual services which the hospital offers and are learning not only their meaning in safeguarding human lives but also their actual cost. Department after department is closely scrutinized while it passes before the reducing ax of trustees and hospital management. The administrator profits from the suggestions of his trustees, while they in turn acquire an intimate knowledge and display a growing interest in the real working problems of conducting so diversified a business. Trustees, when educated to the value of each department, do not wish to see any life conserving service dispensed with, as they take pride, and justifiably so, in the high type of service their institution renders.

Never before have municipal institutions been taxed beyond their capacities and voluntary hospitals been obliged often to say "no" when appealed to for charity. This new situation is forcing the public to recognize that medical and hospital care is a community necessity, and that they must be made available for all who need them. Voluntary hospitals for years have carried willingly a goodly portion of the community charity load. Their reduced incomes will not permit additional charity work without outside help. Hospital groups have frequently appealed to their county boards, their community chest organizations and emergency relief agencies for assistance in meeting this increased need for help. But since these groups frequently had no appreciation of the value of the work the voluntary hospitals were giving to the community their pleas have too often been of no

That communities are recognizing this is evident. Several larger cities have arranged with private hospitals to care for indigent patients at a stipulated price usually meeting the approximate cost of the service. These cities have been brought to realize that provision of hospital care is no more the responsibility of private philanthropy than is the maintenance of public schools, libraries or churches. Inadequacy of the present system of providing for the cost of illness in those groups unable to finance themselves is acknowledged and it may be much easier to obtain appropriations to help pay for this service in the future.

Less Call for Expensive Services

A community is no stronger than the health of its citizens and certainly failure to provide measures for relief of minor ailments during a period of economic stress is poor economy. Such ailments may, if neglected, develop into such degrees of chronicity that the expenditure of large sums of money later cannot reinstate the sufferers as community assets and they will remain public charges.

Those of the middle class are vitally concerned when they learn that the voluntary hospital cannot accept sick members for free service and that they are not eligible for admission to the municipal institution, even though they may be unemployed and without available funds.

The medical profession, always generous in gifts

of service, faces the realization that altruism will not support their families or pay their bills. Conditions have brought about a better business understanding between doctors and patients who are cooperating closely to keep the patient's account as small as possible. The doctor is depending more and more upon his clinical observation and there is less call for the expensive services which the hospital has developed. Many of the luxurious types of service which popular demand required the hospital to provide have been found unnecessary. General duty nursing has become the order of the day unless constant attention is required. Doctors are finding that patients can be well cared for with this service. The public is counting its dollars and is willing to forego frills and luxuries. The low priced accommodation is generally requested. Patients make fewer special requests than formerly and seem equally well satisfied.

No Longer Only a Trustee Problem

Work for the graduate nurse has probably never been at so low an ebb. Many nurses formerly employed in doctors' offices and industrial plants are now unemployed. Special nursing has become a luxury, seldom used except in cases of critical illness and then only as long as it is absolutely necessary. Nurses all over the country are turning to their schools of nursing and the hospitals for help. Various plans are being developed to help them. Graduates are having the opportunity to prove that combined graduate and student nurse service stabilizes the nursing profession—that it is more satisfactory and no more costly in the large hospital and probably not as costly as a good school of nursing in the small hospital. Nurses want and need work and are lending their best effort to help solve the high cost of illness problem.

That it costs money to maintain hospitals and that someone has to pay for every patient cared for, has been forcefully brought home this past year to various relief agencies, to the public through families and friends of patients who could not be admitted, to doctors whose free patients had to be refused, and to hospital boards who found their deficit mounting. Trustees are everywhere in quest of a solution as to how they can maintain a high standard of hospital service at a price that the public can meet. At no other time have they been so concerned with this subject. Because of its peculiar complexity, their problem is no longer only a trustee problem. Through the efforts of the trustees, the medical profession, the hospital administrators, the nursing profession and the social agencies, combined with the indomitable spirit that does not know defeat when the welfare of the people is at stake, hospitals of this country are gradually emerging from the economic depression.

Liability of Hospital for Hot Water Bottle Burn

The plaintiff contracted pneumonia and was taken to the defendant hospital. While he was unconscious a hot water bottle, wrapped in a towel, was placed in his bed near his feet. The towel became dislodged and the plaintiff suffered a burn on his left heel. He sued the hospital and its superintendent for damages. There was a judgment for the plaintiff, and the defendants appealed to the Supreme Court of Oklahoma.

The plaintiff, said the Supreme Court, does not claim that the defendants should not have used the hot water bottle, but contends that in using it the defendants failed to exercise proper care and due caution to see that the bottle did not burn him. The defendants owed the plaintiff the duty of protection against their negligent acts. Although the use of a hot water bottle is proper in the treatment of pneumonia, if it was placed at the plaintiff's feet it should not have been so hot as to cause a burn. There was evidence indicating that it was negligence under the circumstances for the defendant hospital after placing the hot water bottle in the plaintiff's bed not to watch and guard so as to avoid hurting him.

The determination of this fact was a question for the jury and the jury was justified in finding that the hospital had been negligent. The jury, however, was not justified in finding that the superintendent had been negligent.

There was no evidence that the superintendent had negligently employed incompetent nurses for the hospital. Accordingly, the judgment in favor of the plaintiff was affirmed as to the hospital, but reversed as to the superintendent.—Duke Sanitarium versus Hearn (Okla.), 13 P. (2d) 183.

European Schools Charge Student Nurses for Tuition

In Europe, according to reports, it is becoming a common custom for schools of nursing to charge for tuition to nurses in training instead of providing them with subsistence, training and even small money allowances, as was formerly the practice abroad and is the general practice in this country.

In Hungary fees are based on those paid by teachers in training. In France there is a charge for maintenance as well as tuition; in Poland in some schools students pay for tuition and provide their own board and lodging. In all of these countries and in Bulgaria, Czechoslovakia and Italy, where similar systems are in use, full or partial scholarships are available for qualified candidates who cannot pay for their own training. In some instances the holder of a scholarship agrees to serve for a specified period after training under the ministry of health or the Red Cross, or to accept a post recommended by a school committee.

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How to Buy Dairy Products

By F. HAZEN DICK

Business Office, University of Michigan, Ann Arbor

UR national economic distress is demanding that hospitalization expenses be reduced to a minimum, at least for the great majority. Hospital directors are scrutinizing operation costs of all departments in an effort to effect further economies. Efficient purchasing procedure is of significant importance in these attempts.

Considerable publicity has been given the plight of the American farmer, and not the least of these is the dairy farmer. In the following paragraphs I shall endeavor to present a method of procedure for the purchase of milk and cream that should have a stabilizing effect upon this industry and bring about a saving for the hospitals. The factors entering into the purchase of milk and cream are largely dependent upon local conditions, but there are certain general policies that it might be well to study.

Let us consider first the flat rate contract, that is, a contract that specifies the price per bulk gallon, bottled quart or pint, of a certain quality, for a definite period of time, usually ranging from thirty days to one year.

An Unsatisfactory Method for Both Parties

Inasmuch as the market on cream varies from day to day and on milk from month to month, this method requires a vendor to guess at his costs for the period of the contract. If the markets react as the vendor anticipated, the institution may be assured of receiving quality products at a reasonable cost, but if the markets slump, the vendor is in the happy position of making an exorbitant profit at the institution's expense. On the other hand, if the markets advance beyond the vendor's estimate, he will be compelled to deliver below his costs. This method, therefore, usually results in dissatisfaction either for the vendor or the institution.

How, then, may an institution purchase these products at a satisfactory cost and still ensure the vendor and producers a reasonable profit? The price the dairies must pay the producers for milk is decided each month by arbitration with the local producers or producers' association, and on cream by the daily butter market. A purchase based on the vendor's cost of raw milk and cream for the previous month plus a certain per-

centage to cover plant operation, and a percentage for profit, should satisfy all parties concerned.

The producer, that is, a farmer producing a sufficient quantity of milk to warrant his membership in the local producers' association, must be content with the price agreed upon by the officers of his association and the milk dealers. Any variation in this price by producers not in the association, will react in the percentage over cost as quoted by the dealers. The dealer accepting the order will be assured a profit if he did not overlook this item when quoting, and will therefore put forth every effort to give satisfactory quality and service.

By securing competitive bids on this basis, the institution can place a "long term" order for one, two or three years duration with the lowest bidder, ensuring a reasonable cost, and insisting on the specified quality and service. The long term order has a decided advantage over one for a short term, because a dealer can well afford to work on a smaller margin of profit if he is sure of receiving it for a longer period.

Practically all states and cities have laws controlling the production and distribution of dairy products. Many are inadequate, however, in regard to proper health standards, and in cities where this is the case, it would be well to include in the contract definite sanitation requirements. Assistance from the state bureau of dairying commissioner or the professor of dairy husbandry at the state agricultural college will prove invaluable in drawing up these specifications.

The Suggested Purchase Order

The following is an outline for a purchase order employing this method.

John Smith Dairy Co.:

Furnish dairy products listed below for two years, commencing on the first day of March, 1932, and terminating on the last day of February, 1934, at the following specifications and terms.

All products must comply with the local ordinances governing their supply and distribution.

Steam pasteurized milk: The price on bottled milk to be 40 per cent above the price of raw

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milk as paid the producers by the local milk dealers for the previous month.

Examples: Raw milk average for month of February \$2.00 cwt., plus 40 per cent equals \$2.80 per cwt., or \$0.028 per lb., multiplied by 8.5 (i.e. pounds per gallon) equals \$0.238 per gallon.

Bottled milk costs for March.

The price on bulk milk to be 30 per cent above the price of raw milk.

Example: Raw milk average for month of February \$2.00 cwt., plus 30 per cent equals \$2.60 cwt., or \$0.026 per lb., multiplied by 8.5 (*i.e.* pounds per gallon) equals \$0.221 per gallon. (Price for March)

Steam pasteurized cream: The price on bulk cream to be \$0.35 above the daily pound average of the previous month for 92 score butter as published by the U. S. Department of Agriculture, Chicago Market.

Examples: Average price of 92 score butter (Chicago) for month of February \$0.24.

Bulk 20 per cent cream, for March, \$0.24 plus \$0.35 equals \$0.59, multiplied by 16 (*i.e.* number of lbs. of butterfat per 10 gallons of 20 per cent cream) equals \$9.44 per 10 gallons, or \$0.944 per gallon of bulk 20 per cent cream.

The price on bottled cream to be \$0.40 above the daily pound average of the previous month for 92 score butter, as published by the U. S. Department of Agriculture, Chicago Market.

Example: Average price of 92 score butter (Chicago) for month of February \$0.24.

\$0.24 plus \$0.40 equals \$0.64, multiplied by 16 (i.e. number of lbs. of butterfat per 10 gallons of 20 per cent cream) equals \$10.24 per 10 gallons, or \$1.024 per gallon.

Bottled 20 per cent cream for March.

Price on 33 per cent cream figured same as 20 per cent, but using 26.4 as the number of pounds of butterfat in each 10-gallon can of 33 per cent cream.

Price on 40 per cent cream figured same as 20 per cent cream but using 32 as the number of pounds of butterfat per 10-gallon can.

Prices delivered hospital storeroom. Terms net, no discount as per your quotation of

Any other items such as certified milk, skimmed milk, and ice cream mix, may be added to the order on a similar basis. When market conditions are unsettled and extreme fluctuations probable, all parties should be further safeguarded by varying the percentages for a given range of change in the cost of the various raw products.

How Food Clinics Aid in Dietary Treatment

Interest all over the country is awakening to the importance of the food clinic as an aid in the dietetic treatment of the ambulatory patient.

By interpreting the doctor's prescription in terms of the patient's special environmental situation and his dietetic needs, the food clinic serves as a teaching center for medical students, dietetic students and other persons in health work. For this purpose it is necessary that the food clinic be centralized in the out-patient department to which all cases in need of dietary treatment may be referred from the other clinics. The food clinic must be assigned a special place in order that the dietitian will not be handicapped in her work by a lack of facilities.

The following list of helpful articles on food clinics has been assembled by Gertrude T. Spitz, chief, food clinic, Beth Israel Hospital, Boston:

"Fitting the Diet to the Family," by Luise Kraus Addis, Journal of the American Dietetic Association, June, 1930; "A Food Clinic That Serves Both the Hospital and the Community," by Martha A. Alderman, THE MODERN HOSPITAL, September, 1932; "School Children's Nutrition Clinic," by Anna E. Boller, Child Health Bulletin, September, 1932; "A Diet Kitchen in an Out-Patient Department," by Blanche Collier, American Journal of Nursing, November, 1929; "Persistence, Tact, Ingenuity Needed by an O. P. D. Dieti-

tian," by Zelia L. Kester, Hospital Management, June, 1932; "The Dietitian in Social Service," by Lydia J. Roberts, Journal of the American Dietetic Association, March, 1930.

"Teaching Nutrition in an Out-Patient Department," by Gertrude T. Spitz, the Commonhealth, April, May and June, 1932 (Massachusetts department of public health); "The Out-Patient Dietetic Department of Massachusetts General Hospital," Journal of the American Dietetic Association, June, 1928; "The Nutritionist Looks at Mental Hygiene," by Frances Stern, Mental Hygiene, January, 1930; "Food Clinics and the Medical Care of the Out-Patient," Journal of the American Dietetic Association, December, 1931; "A Workshop of Life," by Frances Stern, the Commonhealth, January, February and March, 1931; "Considerations in Planning a Diet," by Stern, Hacker and Faffman, Trained Nurse and Hospital Review, January, February and March, 1931.

"The Use of National Foods in Treating Diabetic Patients of Foreign Birth," by Stern and Reyner, Journal of the American Dietetic Association, January, 1927; "The Food Clinic as a Center for Teaching and Training Students," Journal of the American Dietetic Association, September, 1927; "The Out-Patient and the Diet," by Arthur S. Strauss, Journal of the American Dietetic Association, vol. 3:4; "The Health Program of the Dental Clinic," by Ruth L. White, the Commonhealth, October, November and December, 1928; "Food Clinics," the White House Conference, 1932.

Model Operating Room Is Feature at A Century of Progress

By CARL A. ERIKSON

Schmidt, Garden & Erikson, Architects, Chicago

AN IDEAL operating room: Such were the brief, yet complete and exacting instructions laid down by the Electric Light and Power Industry for this part of its exhibit at A Century of Progress.

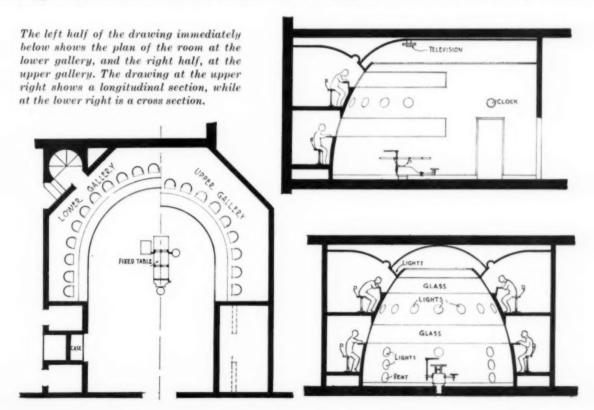
It was not to be an ideal specialty operating room; it wasn't to be like this one or that one; it was not an ideal tempered to suit someone's pocket-book; it wasn't an ideal fitted into spaces left between pipes and columns and the floors above and below; it wasn't even to be fitted into a department; it wasn't to be an ideal compromised into mediocrity. It was merely specified that it should be an ideal operating room. Such a request would make any architect reach for his T-square.

There no doubt is much difference of opinion as to what constitutes an ideal operating room. However, since the operating room is simply the housing for surgical procedures, in the ideal one, the housing should neither be seen nor heard. The patient should be the sole concern—the surgeons, the nurses, the room, the equipment and even the architect—are only necessary incidentals.

The patient gives little thought to this place where he steals the show—where he is the focus of all eyes. If he expressed his ideas he would probably advocate the best of working conditions for the surgeons and nurses, absolute cleanliness, an attractive appearance (if he is to be ushered to the stage while still conscious), and the absence, until he is unconscious, of the terrifying "maskeraders."

Must Consider the Students

The patient's demands are modest except in that one particular about the best of working conditions for the surgeons and nurses. These would include "room enough," perfect cleanliness, perfect lighting, every mechanical accessory close at hand, and absence of noise and confusion; in



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short, a work shop that allows concentration on the serious business at hand.

The ideal operating room can be found only in the hospital, and a hospital without some form of teaching is not complete. But students, whether undergraduates or interns cannot be admitted to the operating room safely. On the other hand, if they are not admitted to the operating room, and even if space is provided for them in galleries or in modern amphitheaters, they are unable to get a good view of the operating field.

A Complete Air Conditioning System

The operating room described here was designed as an ideal room that would meet all of the requirements of surgeons, nurses, students and patients. It has been installed in the Electrical Building at the exposition in Chicago. It is constructed on a reduced scale, one-quarter actual size.

The room is 18 feet wide and 24 feet long at the floor line. The front end of the model is open and represents the corridor or adjoining room wall. The back end of the room is semicircular. The dimensions permit of a "clean" area 12 feet in diameter, a 2-foot ambulatory between the wall and this area and a larger traffic way at the entrance. The area is liberal for comfortable working conditions, large enough so that there need be no danger that the scrubbed personnel and the aseptic area are invaded by the unscrubbed personnel, and yet not so large that it is a burden for cleaning and other maintenance.

Perfect cleanliness is perhaps a physical impossibility, and even if it were once obtained it would not last long. It is a known fact that the outside air in large cities, where the largest and busiest hospitals are found, is dirt laden. To ensure, so far as possible, clean air for the operating room it is necessary to clean the air by mechanical methods. Clean air, however, cannot be maintained in the operating room if there are other sources of fresh air supply, such as a window. Experience has demonstrated that a window that can be opened in a room that is supplied with conditioned air inevitably results in the window being opened at times, thereby admitting dirt laden air into the room. Therefore, if the windows are required for light, they should be fixed so that they cannot be opened.

But in many places such a room would be intolerable during the summer months. Therefore, to ensure cleanliness, it is proposed that this ideal operating room be completely air conditioned. The fresh air introduced would be thoroughly cleaned by any one of several methods that have been proved satisfactory. It would be heated in the winter and cooled in the summer to the temperatures

desired by the surgeons. At the same time, the humidity could be fixed as desired, for, with the heating and refrigerating plant, both temperature and humidity can be automatically controlled. The air conditioning plant, therefore, provides the maximum of cleanliness and at the same time adds to the comfort of both the patient and the personnel.

Just as air conditioning has eliminated the necessity for the window as a source of ventilation in the operating room, so has the electric light eliminated the window as a source of light. All surgeons have not agreed that the north light provided in practically all operating rooms is unnecessary, yet surgical nurses will confirm the statement that in spite of the large windows and skylights, the surgeons almost invariably request that the artificial light be turned on. The various forms of lighting now available produce a quantity and quality of light that is as unchanging as the pyramids. Consequently, no windows are provided in this ideal room.

The lighting system is in two parts. The indirect cove lighting in the ceiling is for general illumination. While the indirect lighting system may be used during the operation if the surgeon desires, it is intended primarily for lighting during the preparation of the room. The model does not indicate all the possibilities of the indirect lighting arrangement, but through the use of dimmers, colored lights and other attachments the patient may be ushered into a room and anesthetized under conditions that are attractive.

A New Type of Students' Gallery

The lighting for surgery consists of a row of bull's-eyes and a single powerful beam from an outlet in the ceiling directly above the operating table and focused on it. Each light is controlled separately and the directions of the light are so varied that any type of light desired by the surgeon may be arranged. For most operations only a part of the upper row of lights would probably be needed. If more horizontal light were needed, the lower light could be used.

The absence of windows in this room eliminates the necessity for shades or similar devices which are used, usually with unsatisfactory results, when an operation requires a dark room.

The admittance of students into the operating room is a potential menace to the patient and is a nuisance to everybody else. If and when television becomes practical it may be possible to allow the students to remain in their classrooms and thus transfer the operation to the classroom. Under present conditions, however, students must be at the operating room. They should be able to see

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what is going on as clearly as the surgeon himself, and yet not be in the aseptic area. The surgeon must be able to talk to the students as he proceeds and the students should be able to ask questions. Viewing an operation from the usual type of amphitheater is about as satisfactory as watching a horse race through the wrong end of a field glass. If some one of the personnel around the table does not block the observer's view entirely, the things to be seen are so minute that even those who are in the front row are unable to see clearly. To eliminate the observer from the operating room yet to permit him to see and hear better than is ordinarily possible may seem paradoxical, yet that has been done in this operating room. The students are

the table, none of whom is more than ten feet from the operating table—a very unusual arrangement.

The desire to improve teaching conditions in the operating room is the reason for the unusual shape of the room. In studying the picture of this room it should be remembered that the operation has been set up so that it can be seen by those who will pass the open end of the model. Normally, of course, the operation would be turned around so that it would be visible to the students in the galleries instead of, as in this case, to those on the outside.

Perhaps if each student equipped himself with a pair of opera glasses no further improvement in visibility would be needed. But the model suggests



completely separated from the operating room in semicircular galleries. The galleries have long, low glass filled openings through which the operation may be watched. The lower gallery has seats for twenty-two students, and the upper one has eighteen seats. The upper gallery projects in front of the lower gallery, and therefore is almost as close to the operating table as the lower one. The eye of the observer in the lower gallery is nine feet and in the upper gallery it is but ten feet from the center of the operating table. For most operations, the upper gallery seats are much to be preferred because the observers are able to see over the heads of the personnel around the table and directly into the wound. Forty spectators are gathered around

another aid to vision by means of the television apparatus at the ceiling directly over the table. Television authorities say that it will not be long before television will be practical for the limited use suggested here. It is proposed that the image of the operation be projected on the end wall, considerably enlarged, so that every detail may be observed by the students. As this wall is absent in the model, the image is represented by the opening alongside of the model on which a drawing of the operation is being projected. No x-ray film display box is shown because a screen will be placed on the end wall, alongside of the television screen, to which the film will be projected.

Of course, the now familiar microphone on the

anesthesia table and the loudspeakers in the galleries explain how the students hear the remarks made in the operating room. And if desired a number of microphones in the gallery and a loudspeaker in the operating room would permit the students to ask and answer questions. The address system might be arranged so that without touching anything the surgeon could summon equipment, nurses, dictate histories and call for and receive laboratory reports. Another type of nurses' call system is suggested by the use of the photo-electric cell. To summon a nurse from without, it will only be necessary for a person in the room to pass his hand through the beam of light which would in turn actuate a nurses' call system of the usual type. The person calling the nurse need not touch anything in order to operate the call system. The photo-electric cell could also be used at the doors to the operating room so that the surgeon on entering would not need to touch the door.

Table Is Fixed in Position

During certain operations the floor of the operating room becomes covered with a web like mass of hose and wires for suction, electrical saws and knives, compressed air, cardiograph, head lamps, etc. Floor connections have been used to eliminate this mass of material on the floor, but they have hitherto been found wanting because of the inherent difficulties. Many methods of overcoming this difficulty were considered, but it was not until it was decided to fix the operating table in position that a wholly satisfactory solution was found. The operating table is constantly becoming less mobile and heavier as additional devices are added to it. But with the table fixed in position, the connections needed at the table may be brought into the base of the table, where connections may be left for any kind of outlets that may be wanted.

The fixed table also eliminates the gas tanks, for the anesthetic gases may be piped from the central gas tank room to the base of the table, and thence by short, flexible hose to the anesthesia machine. Who is there to mourn the passing of this old time sore? Since the table pedestal is securely fastened to the floor, the top may be placed in any position without danger of the table tipping over. The top may be rotated and any position may be obtained by the easily controlled electric motor.

The anesthesia table serves both as the gas machine and the anesthetist's table. When not in use, the gas machine may be lowered into the table and out of the way. There is complete automatic recording of the anesthesia, and a loudspeaker in the base of the table which, when connected to the patient, amplifies the heart beat to make it audible.

The other furniture in the room is the usual

equipment. It has been designed to suit modern manufacturing methods. The anesthetist's stool is bracketed from the operating table, as is the instrument tray. Footstools likewise could be hinged on the base. Thus all loose equipment is eliminated from the operating room. The built-in case carries all of the needed supplies, with a light controlled by a door switch. All of the furniture is finished in hard and durable satin finished chromium plate instead of in the easily damaged and soft baked-on enamel,

Many persons will say that a room such as this without outside windows and wholly dependent on artificial light and ventilation cannot be more than a pipe dream. But there are many operating rooms today where outside light is practically always excluded, particularly those for ear, nose and throat work. In 1927 we designed and built two operating rooms without windows for one of the university hospitals in Chicago. The only air conditioning for these rooms is a fresh air supply admitted through a simple unit heater. After several years' trial these rooms proved so satisfactory that an adjoining operating room that was completed twenty-five years ago and had the usual wide north window fifteen feet high and a liberal skylight has recently been converted into a dark room by painting the windows and filling in the skylight. This was done at the request of the surgeons. These rooms are without air conditioning other than a fresh air supply and yet, summer and winter, for years, they have proved to be quite satisfactory.

There may be, in exceptional localities, some value in the bactericidal effect of sunshine or light of a north window. This matter must be left to the scientists to determine. Possibly an ultraviolet ray lamp would afford an adequate substitute, if used at suitable times and in proper quantity, to sterilize the rooms completely when the patients are out of them. This method would save money by eliminating the heat loss caused by the large windows now usually provided in an operating room.

Such are the reasons that governed the planning of the operating room shown at the exposition. What there is that is new about it, is based on well established principles in successful use in other fields, and adopted in an effort to make the operating room safer for the patient, and a better place for the surgical and nursing staff to work.

The usual acknowledgments are inadequate to express appreciation to those who enthusiastically cooperated in the results achieved. Dr. Paul B. Magnuson, professor of surgery, Northwestern University, not only supervised the technical details of the operation shown but his approval of the basic principles and his helpfulness on all details were invaluable. Charles G. Beersman, supervising architect for the entire exhibit (of which the operating room is but a small portion), was never at a loss in meeting the technical difficulties of building the model and his advice on the many problems that arose was always constructive. Mr. Herzog and Mr. Schaerff of the Scanlan Morris Co., Madison, Wis., designed the operating tables and other furniture, McKesson Appliance Company, the anesthesia table, G. Wallerich of V. Mueller & Co., the instruments.

Practical Administrative Problems

Courtesy Pays Big Dividends in Every Hospital Department

In this department dealt with the psychologic aspects of human relationships as they affect hospital administration. Motives underlying the acts of the members of the board of trustees and of the superintendent were explained. Hospital staffs were reminded of the advice of Robert Burns who suggested searching for the gift of seeing ourselves as "ithers see us." Were such insight possessed by all those engaged in hospital work many misunderstandings would be avoided and the patient would receive effective treatment in an even greater measure than is now possible.

Insofar as the superintendent himself is concerned, a searching self-examination and a more general understanding of his motives by others appear desirable. This is particularly true in view of the fact that the tenure of office of the hospital administrator is exceedingly uncertain. In some states a considerable percentage of hospital administrators hold their positions not longer than one year. This condition cannot always be traced to outstanding faults on the part of the superintendent himself. Some superintendents are inefficient because they lack training. Others are well prepared but fail to produce their best work because they have no tact. But no doubt there are many who fail to render effective service because their superior officers, the members of the board of trustees, are not careful in observing proper administrative procedures.

Behavioristic Traits May Develop

It has been said, not without truth, that many technicians, surgeons and nurses are better trained for the performance of their specific duties than are the hospital superintendents under whom they work. Certainly all physicians are better equipped for prosecuting staff duties than they are for directing a hospital. And yet the best of technical training does not guarantee tact, understanding and administrative humility.

The psychology underlying the nursing of patients is often fraught with self-forgetfulness and

a high desire for service on the part of the nurse. Yet behavioristic traits frequently develop which not only reduce the effectiveness of the nurse but also create false beliefs as to her aims and motives in the mind of the public and of the hospital personnel. The superintendent of nurses resents interference by the superintendent of the hospital in matters pertaining to her department. In some cases she is justified in doing so, for many hospital directors do not think in terms of the nurse's education.

Leaders Condemn Class Distinction

In numerous instances a policy is adopted which tends to save money on school activities regardless of its effect on education. There are institutions in which pupil nurses are required to perform menial tasks with no bearing whatsoever on nursing education. The requisitions of the directress are inordinately pruned with the result that the moral contract existing between the probationer and the hospital is often broken. The directress in turn develops a defensive attitude in her dealings with hospital authorities. She resents any interference, as she terms it, in the discipline of her school and her attitude is often justified. As a result of this psychology she is inclined perhaps to become too loyal to her profession and, by so doing, to fail to appreciate the local need for teamwork. It is not suggested that the directress of nurses should sacrifice a principle, whether ethical or educational, without endeavoring to prove the fallacy of such an action. But in a training school for nurses, as in every other hospital department, there must be no attempt at isolation and no development of a harmful degree of autonomy.

The leaders of modern nursing are inclined to frown upon class distinction. Time was when probationers enjoyed no social relationships with juniors, juniors were ignored by seniors and graduates did not condescend to dine with undergraduates. The psychology underlying such subjection of the lower classes of nurses to personal or professional humiliation is far from healthy. What

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matters an added frill to the cap or variation in the cut or color of uniform except that they are signs of greater ability to serve the patient. The directress of nurses who insists, except to recognize in broad terms proper administrative methods, that lines of class distinction be closely drawn is permitting unfairness in the conduct of her school.

The superintendent of nurses certainly loses by not being brought in closer contact with patients. A certain softening of spirit must result from the actual nursing of the sick. Moreover, while strict discipline is absolutely essential in the conduct of any school, the wise directress never assumes the attitude of an unbending martinet. Her pupils obey because they are convinced that this is the right course. They observe the rules of the school because a splendid vision of service has been created for them and exemplified by their superior officers.

Social contacts within the hospital should be with the group and not with the individual. They should not include specific social invitations from board members or others to any one member of the institution's personnel. This general rule is particularly applicable to the school for nurses and the directress certainly errs who singles out any pupil or graduate nurse for the bestowal of special favors. The psychology of discipline in the school for nurses varies in no great degree from that in other hospital departments.

Directress Must Be Open-Minded

It is hardly necessary to add that she who harshly criticizes a pupil nurse in the presence of others offends as certainly as she who endeavors to rule by fear alone and not by the force of her own character. There are many splendid opportunities for good deeds inherent in the position of the superintendent of the school for nurses. But the reverse is also true. The carping, shortsighted, tactless directress may work much harm.

The head of the training school often finds her relationship with the members of the visiting staff a difficult one. She must hear with equanimity complaints of all degrees of seriousness against the members of her school. She must realize that the physician in such an instance is often inclined to individualize strongly because the error directly affected his patient. She must understand that such complaints are often just and not actuated by personal motives. The directress who defends her nurses on all occasions whether they be right or wrong is more loyal to her school than she is to the patient. Each complaint must be received with an open mind, investigated thoroughly and proper punishment promptly meted out. Other-

wise the visiting staff soon loses faith in the school and its directress.

The supervising ward nurse often develops a highly commendable zeal for service to the patient. Brought daily into working contact with both patients and pupil nurses, she is a most important unit in weaving the garment of service. She has in her control the welfare of a large number of patients and perhaps more than any other one person can make or mar the good name of the hospital. She often occupies a most difficult position. In some institutions she is the practical administrator and enforcement officer of hospital rules insofar as they affect her department. In carrying out this function she comes in contact with interns in a way which is bound to lead to harmful personalities if she is not tactful.

Partiality Generates Strife

Often there is no other administrative medical officer in the department except the supervisor or head nurse. This is particularly true in institutions not employing the resident physician system. There are eminent physicians today who can trace their first instruction in performing ward dressings and in carrying out minor surgical procedures to the tactful direction of a graduate floor nurse. This type of nursing officer must be proficient in many angles of work. She must be the practical supervisor of the pupil nurses. She must also be ward bookkeeper, housekeeper and liaison officer between the staff and the training school. She comes in contact with the various visiting physicians. She must develop an attitude of fairness to all.

She may, however, permit herself to show partiality to certain staff members. She may be tempted to make more thorough rounds with some than with others, to provide patched gloves for one and new ones for another, to supply better instruments, better service and higher praise to the physician of pleasing personality than to the one who is inclined to be offensive. This psychology is harmful to ward work and should be strongly discouraged. Any nurse who displays an attitude of hauteur toward probationers or newly appointed interns is bound to fail as an administrative officer. She is not only working harm to her profession, but she is generating strife between physicians and nurses and is seriously affecting the morale of the ward unit in her charge.

The psychology of the operating room supervisor is highly interesting. The work of this department is of a technical nature. The welfare and even the very lives of patients brought to this division are in the hands of these nurses. If an attitude of unquestioning adherence to rules and

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to scientific perfection of procedures is ever justified, it is here. The operating room supervisor must be a martinet. She must demand of her subordinates full knowledge of all details of surgical work and must countenance no error in technique.

The surgeon during his stay in the operating clinic is under high nervous tension which often leads to a frequently misunderstood irascibility. There is no place in this department for a supervisor who cannot control herself at all times. The visiting physician often assumes an unreasonable attitude of resentment when he is required to obey rules in the making of which he may have had a prominent part. A curious situation thus arises. The operating room supervisor must require adherence to rules which the surgeon apparently feels are made only to be broken. Younger members of the surgical staff occasionally resent being required to mask and gown, to scrub ten minutes, when they are late, or to don operating suits for the performance of what they deem minor procedures. When such difficulties arise no enforcement officer is at hand to support the operating room supervisor who is placed in the difficult and unorthodox position of enforcing a rule contrary to the physician's desires.

Supervisor Has a Difficult Task

The scheduling of operations in a busy clinic often presents peculiar difficulties. The rule of priority of schedule is a sound one and would appear to offer no possibility of offense to anyone. And yet a distinguished surgeon often becomes irritated when he is informed that he may not operate at a desired hour because another has scheduled a procedure before him. He cannot understand why he must wait until afternoon for his surgical work when he much prefers to treat his patient in the morning and to recreate later. This and many other minor difficulties often tempt a supervising clinic nurse to criticize the surgeon's work in her department. Such criticism would appear sometimes to be justified even though it does not come in good grace from a nurse.

The supervising nurse learns much concerning the earmarks of good surgery. She has an opportunity to recognize indecision and errors in technique as they occur daily before her eyes. She often has an opportunity to be helpful to the young surgeon. Because frequently she has no one to support her insistence on rule observance, she must rely on her own personal strength of character to conduct her work properly and safely. Thus she is frequently looked upon as hard and cruel, unreasoning and autocratic, but she rightfully must bear these stigmas if she is to fulfill

properly her obligations to the surgeon and to the patient.

She must present an open-minded attitude when infections occur. Although she may not look with calmness on the perennial placing of the blame on catgut, yet she must not form final judgments until a thorough investigation has been made. Moreover, errors of technique by her own nurses may be wholly responsible for the accident. The operating room nurse, therefore, must develop self-reliance and must be a stern disciplinarian. She who would seek the easiest way has no place in this department. It has been remarked that enforcement of rules often must be brought about after overcoming resistance of certain members of the staff. Fortunately these cases are in the minority.

Teaching Loyalty to Principles

Economy in the conduct of the operating suite is almost unknown in many institutions. The saving of gauze and cotton, of instruments and ether, presents many possibilities. An efficient operating room supervisor knows the best method of bringing about this economy.

The psychology of the pupil nurse is likewise an interesting subject. Plunged for the first time into a new world of closely intermingled educational and practical requirements, the pupil nurse comes face to face with a discipline more strict than any she has ever known. She is apt to develop an attitude of fear and, at times, one of false loyalty. Perhaps no lesson is more difficult to teach than that of loyalty to principles rather than to persons. The student is inclined to protect her colleagues even though she endangers the welfare of the patient. As her course progresses her vision widens and the nurse who possesses the qualities of leadership soon makes her presence felt. With sickness and suffering the young nurse is largely unacquainted. It is remarkable, however, how soon she develops a sense of responsibility and an attitude of self-forgetfulness.

Problems relating to the pupil nurse which come to the attention of the directress are often due to the pupil's immaturity rather than to a lack of desire to perform her work properly. There are many who prefer to have patients nursed by pupil nurses because they can be more easily guided and more strictly conform to institutional rules. The attitude to be developed in this group is that which creates a desire to do right, to perform work well because it has been proved that the patient will be most benefited thereby.

Two persons in the hospital hold the reputation of the institution in their hands to a large degree—the information clerk and the telephone operator. This is true because these two officials come in

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close contact with the public and also because the average lay person is not qualified to form an accurate opinion as to the adequacy of the specialized practices of medicine and surgery. First impressions are often lasting. The distressed relative of the patient is likely to contact first with the information clerk. If he is received with understanding and kindness a fine service has been rendered the hospital. If, on the other hand, the information desk is in charge of one who is blasé, curt and unkind, even if unintentionally, the unfavorable impression made will certainly generate resentment and distrust on the part of the patient and his relatives. This official should not adopt an attitude too businesslike or too efficient. It is surprising how quickly kindness and understanding on the part of a hospital employee are reflected by a changed and conciliatory attitude by one previously critical. These same remarks apply also to the hospital cashier, credit worker and all others who come in contact with distressed human beings.

Selling the Hospital's Wares

The telephone operator may make or mar the hospital's reputation. Curtness is often more offensive on the telephone than when it occurs between two persons in conversation. The telephone operator who fails by tone of voice or by word of mouth to display a desire to alleviate anxiety and to quiet fears fails to take advantage of a splendid opportunity. Since perhaps more telephone calls than personal visits are made to the average institution, the hospital superintendent should use care to select a capable operator.

These suggestions apply also to the admission office. In fact, here is a practical possibility of extending hospital income through courteous and effective salesmanship. Here, moreover, exists the need for a proper appreciation of the hospital's wares. The suggestion that a slightly more expensive room be selected because the stay in the hospital is to be short is often readily accepted by the patient or his relatives. Courtesy pays just as large dividends here as it does in other hospital departments.

Importance of the Accident Ward

In the institutional accident ward representatives of the public are inclined to display abnormal traits which must be understood to be properly met. Frightened and distressed human beings come here for first bits of information in regard to the injuries of loved ones. Here one sees fear hysteria in its highest degree and tactful handling of both patient and relative will prove worth while. Here are splendid opportunities for developing real gratitude to the hospital on the part of the patient and others for effective and humane service when they need it most.

When an indifferent attitude is presented delay in treatment is apt to result and criticism of the hospital is sure to follow. Instead of placing less highly trained physicians and nurses in the accident ward, the greatest care should be exhibited in selecting this personnel. Not only is such care likely to save lives, but here, of all places, the public has a right to expect prompt, courteous and scientifically effective service from the hospital.

The Well Equipped Ambulance— What It Should Contain

The ambulance should consist of something more than a mere automobile with facilities for carrying a recumbent patient. The equipment of the average ambulance should consist, first of all, of a proper and easily removable stretcher, preferably elevated from the floor, and every precaution should be taken to ensure that the patient can be easily placed in the ambulance and easily removed upon arrival at the hospital.

In too many hospitals there is a lack of supervision of ambulance linen and equipment. Frequently the ambulance driver is relied upon to see that linen, blankets, towels and pillowcases are changed as often as necessary. In other hospitals it is required that the ambulance be driven to the accident ward daily where an inspection is made of the equipment by the graduate nurse in charge, who is responsible for keeping the linen and blankets in the proper sanitary condition. Certainly, sheets and pillowcases should be changed whenever soiled and usually after every patient has been brought to the hospital.

Some type of resuscitation equipment should be found

in the ambulance. Sometimes this consists merely of an oxygen tank with a mask, or again of an oxygen and carbon dioxide tank with a mixer, for the treatment of carbon monoxide poisoning. Inspection of this equipment should be in the hands of a graduate nurse.

The physician's emergency bag should be well stocked and should be stored in the accident ward between trips. A daily inspection should be made of this bag in order to be certain that drugs and instruments have not disappeared and that both are in a serviceable state. The bag should of course contain a complete supply of emergency drugs and instruments, and an obstetric bag ready for use should probably be stored as a precautionary measure in the closet of the ambulance.

Constant Supervision Is Needed

While it is possible to have too extensive equipment supplied to the ambulance, it is better to err on this side rather than not to have available ordinary emergency supplies for unexpected uses. Above all, it should be the duty of the nursing force of the hospital to supervise the cleanliness and equipment of the ambulance in the same methodical way that the ward medicine closets or the operating rooms are supervised.

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The Problem of the Month

How Can Hospitals Eliminate the Ambulance Chasing Racket?

AN EDITORIAL in the May number of THE MODERN HOSPITAL called attention to the ambulance chasing racket, particularly as it has been carried on in connection with the emergency hospitals in San Francisco.

The director of public health in that city recently suspended from duty several physicians, hospital stewards and attendants, and dismissed some persons from the service. Certain employees, according to the press reports, were even willing to tamper with x-ray films to show the presence of fractures should the film fail to show clearly that a fracture existed. The startling revelations serve as a reminder that similar destructive and dishonest practices may be going on in other parts of the country.

What action have you taken to safeguard your institution from unwittingly participating in this sort of racket?

P. J. McMillin, Superintendent, City Hospital, Cleveland:

"The ambulance chasing racket is a vicious activity and one that hospitals, especially public hospitals, have always faced. I do not believe this activity can be entirely eliminated. Two things, however, can be done by hospitals.

"It is well to limit to the immediate family visitors to patients who have been admitted as accident cases, and to set up restrictions that will prevent visiting by an attorney during the time the patient is in the hospital unless the visit of an attorney is requested by the patient or patient's relative.

"When an attorney requests permission to see a patient, he should be requested to sign a statement in which is included his declaration that he has been retained to represent such patient. Then this statement should be checked with the patient. When the facts indicate the attorney has made a mistatement, the facts in the case should be reported to the local bar association.

"I believe that if the above two suggestions are

adopted in all hospitals as policies ambulance chasing will be materially reduced. I am certain that at City Hospital the activity has been materially cut in volume by this means."

Mabel Davies, R.N., Superintendent, Beekman Street Hospital, New York City:

"The investigation of ambulance chasers conducted by Judge Wasservogel of the New York Supreme Court about three years ago resulted in the disbarment of many old-timers and badly frightened others. A number of these are said still to be operating through other attorneys.

"The existent law in New York requires that a notice of retainer be filed with the court before the case can be entered on the docket, and the records of the Supreme Court disclose that fewer of these cases are being tried at the present time. It is believed that in effect conditions in New York are the same as before the investigation, but that inasmuch as an entirely new crop of lawyers has entered the ambulance chasing field, equipped with the knowledge and information acquired at that time, they are now handling cases in such a tactful manner that fewer complaints are received. Judge Wasservogel stressed, however, that drastic action would be taken by the court in any case brought to its attention, and that the report of such cases would certainly have a tendency to lessen the irreg-

"About 4,500 calls are received annually by Beekman Street Hospital ambulances. Several years ago when our interns and chauffeurs were continuously approached by ambulance chasers, each entering group was warned that summary dismissal would result upon receipt of reliable evidence of any form of connivance with ambulance chasers. This rule is still in effect, close surveillance is kept on visitors and suspicious visitors and lawyers are conducted to the patient by a member of our staff handling liability and compensation cases. By these means, and with the cooperation of the professional staff and employees, we have

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practically eliminated the annoyance at Beekman Street Hospital.

"Innumerable requests are received from lawyers for records of our treatment of minor accident ambulance cases. Knowledge of these accidents could have been gained only from the police blotter, to which any person may have access, and we believe this to be a common method adopted by ambulance chasers in order to obtain information."

Charles A. Wordell, Director, St. Luke's Hospital, Chicago:

"The ambulance chaser has been for many years a problem to hospitals, especially where they are looked to as a center for the handling of many emergency cases, and where there is high concentration of population. The methods adopted by unscrupulous lawyers, regardless of the city, seldom deviate.

"The rule adopted by this institution, which has resulted in almost complete elimination of this practice, is to admit only relatives to ward patients with written passes provided for this purpose. An agreement to this effect is made at the time of the patient's admission or when relatives appear.

"The charge nurse obtains the pass and identifies the visitor through the patient before permitting the visit. Claims agents must show proper identification before the privilege is granted. All personnel, including professional, are warned that immediate suspension is the penalty for any attempt to recommend lawyers or provide information regarding injured patients."

Dr. B. W. Black, Medical Director, Highland Hospital, Oakland, Calif.:

"One hospital quite recently found that a male nurse employed in the fracture ward in the emergency section of the hospital was being paid by certain interests each month and his sole duty was to inform his employer of the names of persons admitted as accident cases to that ward. It was even found that patients on the wards whose stay was prolonged and whose friendship had been cultivated by these ambulance racketeers, served as active solicitors for them. In another hospital where a real effort is made to establish favorable press connections for legitimate publicity purposes, ambulance chasers representing themselves as members of the press have telephoned the hospital to secure the names of accident victims. This condition was met by requiring that the legitimate newspapers of the community should place a written list of regular reporters on file at the hospital, and only to those reporters was information given concerning accidents.

"For a hospital to eliminate from its accident wards this pernicious practice, eternal vigilance as to whom information is given must be exercised by the administration. This can best be done after scrutinizing the personnel on duty at any time and eliminating those who are not entirely trustworthy; by insisting that any information given out concerning any patient shall be given only on the express written order of the patient signed in the presence of witnesses. The district attorney in one county in supporting this position has ruled that all records whatsoever referring to a patient under treatment, given even emergency care, are confidential in character, and are not open to the public, and that the contents of such records can be disclosed only in the interest of the patient, or by his written order.

"Such a policy would have the support of the American Bar Association and the legal profession in any state whose members are earnestly and sincerely attempting to eliminate ambulance chasing from hospitals and free their own profession from such influence."

Dr. F. G. Carter, Superintendent, Ancker Hospital, St. Paul, Minn.:

"The ambulance chasing attorney may establish his contact with an accident case in a hospital through an orderly, a nurse, an intern, a physician or any other employee who is in close touch with the accident department. Usually he wants prompt information concerning the presence of accident cases in the hospital and is willing to pay for this information. The attorney himself, or one of his runners, acting upon the lead thus obtained, will visit or attempt to visit the patient whom he seeks to serve. Attorneys stooping to these methods are often incompetent and unscrupulous, and patients engaging them may have undesirable representation as a result. Their willingness to pay and their influence over hospital employees may lead to actual distortion of clinical facts through meddling with records.

"Repeated inquiries coming from firms of attorneys within a day or two after accident cases have been admitted to the hospital should be looked upon with suspicion. The average accident case does not seek legal advice immediately upon admission to the hospital and the inference may be drawn that legal advice has sought the patient when such inquiries follow rapidly the admission of the patient to the hospital. The practices of firms who are repeated offenders in this respect

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should be investigated through inquiry among ethical legal practitioners and the local bar association.

"A careful scrutiny of visitors in order to detect runners employed by ambulance chasing attorneys should be carried out in every hospital. Frequent appearance of the same visitor to different accident cases will usually be noted by wide-awake clerks in charge of directing visitors. The visitor under suspicion may be asked to wait until the patient is communicated with privately relative to his acquaintance with the visitor in question. If acquaintanceship is not established, the visitor may be refused admission.

"The curtailment of booth telephones and private telephones not operating through the hospital switchboard is advisable. This makes it difficult for confederates in the hospital to communicate promptly with their principals on the outside. When it is discovered that any employee is supplying information about accident cases to ambulance chasing attorneys, that employee should be dismissed from service immediately."

Brig. Gen. R. E. Longan, Superintendent, Baltimore City Hospitals, Baltimore:

"Ambulance chasing is an evil that can never be wholly eradicated while there are dishonest men. We must expect it forever in some form. The best we can hope for is a reduction of the evil. All right thinking people abhor the ambulance chaser.

"To suggest more laws is an unpleasant thought, yet it seems that laws with teeth are the only solution. Ambulance chasers and all who connive with them are a conscienceless group to whom no effective appeal can be made. Their action can be limited only through fear of consequences."

George D. Sheats, Superintendent, Baptist Memorial Hospital, Memphis, Tenn.:

"I am sorry to say that I find the ambulance chasing racket is on the increase. Recently I discovered that some lawyers have employed a woman investigator who calls on patients soon after they are injured.

"I find that the best way to discourage this practice is for the hospital to report to the bar association for investigation any lawyers who are suspected of having too many accident cases. These lawyers can be determined by the records they request. I have done this in a few instances and the bar association has cooperated fully.

"I realize, however, that this is only a feeble effort, as the majority of the offenders slip through our fingers."

M. H. Eichenlaub, Superintendent, Western Pennsylvania Hospital, Pittsburgh:

"Fortunately, we have experienced but slight difficulty from the pernicious practice of ambulance chasing. We exercise precautions to prevent unauthorized persons from gaining access to injured persons at the time of admission or during the patients' stay in the hospital.

"The hospitals in this section of Pennsylvania were recently edified by the action of the Allegheny County Bar Association, which resulted in the disbarment of several unethical attorneys. Needless to say, immediate suspension followed by dismissal should be the lot of any individual, professional or otherwise, who is found guilty of such a practice."

Sister Mary Rose, Superintendent, Mercy Hospital, Pittsburgh:

"'The bar association has instituted disbarment proceedings against — , attorney, in its investigation of alleged ambulance chasing practices."

"The above quotation, taken from a Pittsburgh newspaper, indicates how the hospitals in this city are dealing with a racket that taps the resources of the hospitals and the medical profession to the amount of hundreds of dollars yearly. Threatened disbarment has proved the most efficacious weapon in securing justice, but it has not destroyed the parasite. Publicity designed to convince the laity that they, as well as hospitals and physicians, are prospective victims in case of accident, is necessary to destroy this vicious practice, for so long as patients are victimized, just so long will hospitals and physicians who care for them suffer.

"The hospital is handicapped in this matter because, as host, it must be courteous to all persons visiting its patients. Unless a runner is caught in some suspicious act the hospital can do nothing but watch. In Pittsburgh young men are employed as runners to solicit this illegal business. These men enter the hospital as visitors, and they are so clever that they capture their victims in spite of vigilance. When the hospital officer approaches the patient thus ensnared, the patient conceives the idea that the hospital is uniting with the insurance company against him. In these cases the hospital can do nothing until a settlement is made, even though hospitalization may extend over a period of months. It is only when the hospital has lost and the unethical attorney has his booty that the hospital can use this weapon and report the case to the local bar association for a thorough investigation."

Editorials

Hospitals and These Changing Times

THE results of the London economic conference may clarify vision and enable our political and business leaders to give more positive assurances to the public. Meanwhile the thoughtful hospital executive is concerned about the effect of rapidly changing commercial and currency conditions on his institution and its financial problems.

Reassuring utterances have been voiced by the nation's chief executive, nevertheless, business minds throughout the country are inevitably concerned with the possible effect of inflation because such experiments have not always been judiciously directed and controlled. That there must be price advances in basic commodities if the American standard is to survive, goes without question. On the other hand, any realignment of the currency system provokes doubt and hesitation—even fear.

Uncontrolled currency inflation it must be recognized, once started, may go to great lengths. Fixed charges such as hospital room and ward rates, lagged far behind in Germany, Austria, Italy and France when inflation was the order of the day in those countries. The dark side of the picture suggests the possibility of marked increases in the cost of operating hospitals without corresponding increases in receipts from patients, endowments and other sources. Viewing affairs in a more favorable light, envisions inflation so controlled as simply to restore commodity costs of, let us say, 1926 and industrial activity increased to the point where larger groups of persons may be able to pay for hospital care.

The wise course of the hospital superintendent would therefore be to prepare against inflation rather than to prepare for it, to take counsel on important purchases with the best informed business men on his board, to consult with his advisory groups on a revised scale of charges for use when, as and if, required and to study any possible effect upon present or proposed fixed rates for handling industrial cases and group insurance.

To meet successfully present and possible exigencies requires not alone the best judgment of the hospital's chief executive; it demands cooperative action on the part of everyone identified with the institution.

The Fee Splitting Evil

THE division of fees by physicians is generally considered an unpardonable breach of professional ethics. Few physicians are inclined to condone openly this practice. No doubt a considerable number, because of economic pressure or frail moral fiber, are led to solicit or to accept some form of reward for referring patients to the specialist. In such a case the specialist and the physician are equally guilty.

But this practice, commonly known as fee splitting, does not always involve the actual giving or receiving of money. Professional favors, gifts of more or less value, fees for assistance at operations or for administration of anesthetics are some of the many types of rewards for referring cases. In the last analysis it is the welfare, even the life, of the patient which is bought or sold under this system.

It is not always the best surgeon in whose hands the life of the patient is placed but rather the one who most readily and unquestioningly prostitutes his own personal and professional character. In whatever way the practice is viewed it is abominable. When such a vice infects a hospital staff the good name of the whole institution is imperiled.

It is the duty, therefore, of the hospital board to be constantly on the alert for evidence of unethical practice among its visiting physicians. When the presence of this ethical ulcer is detected the most radical administrative surgery becomes necessary. Persons must be forgotten and principles remembered if this virulent disease is to be cured.

Practitioners of Nutrition

NE of the characteristics of the progressive administrator is the care and thought that he gives to the power plant of his hospital. While most of this care is in the interest of economy, much of it is due to the fact that the power plant is the heart of the buildings and controls their operation in the measure of the efficiency of its management. The selection of a qualified engineer is important.

It is, however, one of the paradoxes of hospital administration that far more attention is paid to the fuel that goes into the boilers than to the food that is to sustain or restore the patient for whose sake the hospital and its power plant have come into existence. Perhaps this is because the results of failure are more tangible in the first case than in the second. If this is the psychologic explanation, it is all the more regrettable.

Another paradox is the faith that many have in the extraordinary substances that are used in the treatment of disease (such as chemical compounds of various complicated formulas) in contrast with the seeming lack of interest in the routine foodstuffs, which are indeed taken for granted since they somehow manage to regulate themselves. The psychologic explanation for this may be the challenge of the unusual and the mysterious and the craving for immediate spectacular results from "treatment." Happily the remedy for this condition is at hand, although it is not universally applied.

The recent laws promulgated in New York State designed to protect the ethics of the dental fraternity and the efforts to safeguard the public from the poorly trained practitioner of medicine remind us that the recent addition of scientific nutrition (sometimes called dietetics in a restricted way) to the hospital therapeutic specialties has come without the protection that has been given to the others. It is therefore in need of some informal attention on our part.

There are dictitians and dictitians, just as there are physicians and physicians, and the wise administrator would do well to choose for his hospital only those who, qualified by preliminary education, are graduates of schools that would correspond to the Class A of the medical colleges. In this way alone may they be certain of the best available thought for their food departments.

The science of nutrition in hospitals has passed its infancy as a specialty and is now in its full blown adolescent stage, with great promise for the future. There is obvious room for growth and progress and this cannot be accomplished anywhere as it can in the hospital. We know already that the relation of food to health and disease is a vital one and we should therefore choose for its students and investigators the best minds that may be obtained for the purpose through the help of the better schools in this country.

Two Types of Hospitals

THERE are two kinds of hospitals. In one, the board of trustees selects a competent superintendent and whole-heartedly supports him. In the other, the directors meddle administratively and so confuse the minds of the institution's personnel that lines of authority, like the equator, are purely imaginary. In the former, order and efficiency prevail. Dissension and low morale are found in the latter.

If stockings, candy or locomotives can most profitably be manufactured under the first system, why

should the safety of human lives be endangered by the application of the principles of the second method? It is difficult to understand why the conservative, clear thinking business man so often forgets his convictions regarding the advantages of orderly procedure when he attends a meeting of the hospital board. A mediocre hospital executive cannot survive under a board that persists in issuing orders to others than the superintendent. A competent administrator will refuse to attempt the impossible.

Has Social Service Stood the Test?

T HAS been stated that 75 per cent of the factors directly or indirectly concerned with the cause of disease are social in nature. None will deny that poverty, alcoholism and the lack of observance of moral laws form a triumvirate that often produces a state of physical disease. Nor can it be refuted that disease in turn is almost as frequently the cause of these conditions.

But the problem presented to the social worker of satisfactorily unraveling a tangled skein of circumstances that have enmeshed the life of an individual is not one of test tube simplicity. When family funds dwindle and sickness appears the efforts of the most skilled social diagnostician often avail little. The medical social service department of the hospital has been taxed to the uttermost during the past months. Of unemployment there has been much. Fortunately no devastating epidemics of disease have aggravated an already difficult situation. But the social worker has labored unceasingly, endeavoring to maintain the family circle unbroken, striving to preserve the selfrespect of the wage earner and at the same time to procure the necessities of life for his dependents.

Social service has stood the test of fire—it has been the sheet anchor that has saved many a difficult community situation. Moreover, social organizations in numerous instances have supplied the only efficient machinery available for distributing relief funds intelligently and fairly. The medical social worker is not a dreamy visionary who knows not the value of money or the methods of conserving it, as some assert. She has on occasions without number prevented the need for hospitalization by providing food, by obtaining dispensary advice and treatment, without which the occurrence of a more or less prolonged illness would have been inevitable. Social service as a profession and the social worker as an individual have surely proved their worth, have amply justified their existence in the community and in the hospital during these trying days of economic readjustment.

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What About Contract Practice?

THE physician's code of ethics does not countenance contract practice. This term is used to describe loosely a variety of relationships. The physician who promises a cure requiring treatment over a period of weeks or months for a stipulated lump sum surely enters into a verbal contract with the patient. The doctor who gives services and supplies for a fee, whether in the office or covering a day's hospital treatment, in a measure enters into a contract. The practitioner who offers a flat rate for the removal of tonsils or the office treatment of lues is also making a contract.

Every promise, whether written or verbal, to sell service or skill is of a contractual nature. The director of the medical department of a store, a health department or a manufactory is by this standard engaged in contract medicine. A changing order will doubtless require the rewriting of this article of the physician's code of ethics and this should be done unless it can be proved that such action would endanger the welfare of patients.

It is obviously unfair to place a large number of splendid physicians outside the pale because they render this type of curative or preventive service. To take cognizance of this reputed professional error and to overlook more grave ethical defects is to strain at the proverbial gnat and swallow a camel.

Dental Surgery and the Hospital

ASAD commentary on the public and professional conception of the importance of dentistry in curing disease is the fact that in 6,500 hospitals in the field there are only 1,100 dental departments.

Focal infection is a common source of such disabling conditions as arthritis, endocarditis and nephritis. Often the careful internist first inspects the buccal cavity of his patient in search of the cause of his symptoms. In the hospital the prophylactic and curative potentialities of the skilled dentist are undeniable. Every patient admitted to the institution deserves and requires a thorough mouth prophylaxis. The services of the dental out-patient department are of great importance to the hospital and the community. Instruction of children in proper oral hygiene practices in the preventive medicine department of the hospital is highly necessary.

The dentist should rank as a member of the major hospital staff and should be responsible for

prophylactic and curative service for all patients. A resident dental intern and one or more hygienists should complete the personnel of this group. Successful treatment in the hospital of many conditions is impossible without the aid of this department.

False Fears

HROUGHOUT much of the comment on the widely, if not always wisely, discussed subject of medical economics there has run a note of distrust of the hospital's motives. Some physicians seem to suspect that the hospital aims to encroach upon their prerogatives, to usurp the heritage of trust and confidence that they enjoy in the family circle and to lessen their financial rewards for rendering medical service to the public.

Nothing could be further from the truth. If these events should transpire, it would not be the hospital management which alienated the loyalty of the family physician's patients and attracted patients inclined to wander to dispensary or ward. The offenders would be the family physician's own colleagues on hospital staffs. The hospital should, and usually does, refuse to allow unfairness to be worked upon the community doctor. The fact that a lay board has the supreme power of management of the hospital is no disparagement to the professional ability or personal reputation of the physician group, collectively or individually.

Could and would the doctor assume the managerial and financial responsibility now borne by lay boards generally? The average physician has neither means nor business training to take over the conduct of the hospital. Why then this insistence that since the physician refers the patients he should also direct the business of the institution? Many a hospital encounters a deficit because too few patients are referred by local physicians. In such a case the members of the board often meet the deficit from their own resources.

The hospital is but a pile of brick, stone and mortar made alive and useful by the presence of an efficient medical and nonmedical personnel. The lay group provides the instruments of service; the professional group supplies the skill and training. Neither is useful without the other. It is folly to listen to idle but dangerous talk of incendiary agitators who would stir up strife between these two arms of service. Until the doctor is willing and able personally to guarantee to the community that the financial needs of the hospital will be met, he should cease to demand that the administrative institutional reins be put into his hands.

Maintenance, Operation and Equipment

Blankets—How to Select, Purchase and Care for Them

By CHESTER HART, B.Arch.

THE MODERN HOSPITAL, Chicago

This survey of hospital

procedure in regard to blan-

kets will afford a check on the

performance of blankets in

institutions. The conditions

cited should indicate the need

for investigation, and the

application of methods found

economical in other institu-

tions should be profitable.

THE exigencies of these times have forced the hospital to analyze carefully and accurately all its activities. The hospital superintendent has not limited his investigations to the larger purchases of supplies, equipment and labor, but has examined practically every item and operation necessary to the maintenance of the institution. The value of such comprehensive study has been demonstrated by economies achieved—economies that have in many instances reduced running expenses even while increasing and improving service. Good buying methods, proper use and maintenance are responsible for decreased expenses even more than is the decline in prices.

A study was made of twenty-five hospitals in order to determine their procedure in the purchase and care of blankets. Both large and small institutions were consulted. All were of the general type with the exception of one maternity hospital. All wool blankets were purchased by 24 per cent of the hospitals, 16 per cent used both all wool and wool mixtures and 60 per cent used only wool mixtures. The mixtures varied from 80 per cent wool and 20 per cent cotton to a half and half combination. Blankets with the higher wool percentage

gave a greater number of patient days of service than did blankets of low wool content.

The service given by a wool or a mixed cotton and wool blanket depends entirely upon the length of the wool and cotton fibers. A long fiber blanket will have a higher breaking strength and will give longer wear. A loosely woven blanket, or one made of short fiber threads, lacks tensile strength and will wear out quickly. "All wool" is a guarantee of quantity, not of quality. For example, a short fiber or reclaimed

wool blanket may contain 100 per cent wool, but its length of service will be comparatively short. It is necessary to understand types of wool and cotton as well as the percentages.

Considerable divergence of opinion exists as to methods of purchasing blankets for best results. A number of hospitals have standard specifications for blankets and will take bids from manufacturers and hospital supply houses only upon the quality specified. This system allows accurate calculation of depreciation on the basis of past performance of the same quality of material. Some institutions purchase through a hospital purchasing bureau. A few buy blankets through the retail merchant. The specification and bid type of buying has been found highly successful both from the standpoint of quality and of fair price. Letters from the twenty-five hospitals studied show that 36 per cent purchase from hospital supply houses, 32 per cent from manufacturers, 20 per cent from retail merchants and 12 per cent buy from any of these outlets.

One hospital superintendent finds that by purchasing directly from the mill he can obtain a much lower price. Another is insistent on competitive

bids which have resulted in purchases from all three outlets. Others have found that the hospital supply house not only competes favorably in price, but also gives a valuable consulting service on color schemes and proper care. In making purchases from any of these outlets, the responsibility of the firm and its ability to maintain and supply the specified quality of goods must be considered.

The number of blankets to be purchased for any hospital of a given size varies with

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the service. From one to two blankets per bed is the usual allotment. A hospital of 50 beds reported that 50 all wool blankets were purchased when the institution opened and have been in continuous service for eight years. For a 195-bed hospital an initial quantity of 360 blankets of 60 per cent wool content was purchased, half of them being placed on the reserve shelf. Due to careful laundering and the good quality of the blankets, no replacements have been made in five years. Another hospital of 175 beds uses a 50 per cent wool blanket and it is necessary to replace 100 pairs annually. This hospital tried blankets with a higher wool content and found that they did not give added service commensurate with the added cost because the laundry could not wash and dry this better type of blanket satisfactorily. A hospital of 165 beds using blankets of 70 to 80 per cent wool content has an annual replacement of fifty.

Average Blanket Purchase per Bed

Even greater differences in numbers of blankets bought were noted in some instances. The average annual blanket purchase, regardless of wool content, was 4/5 blanket per bed. The lowest ratio for all wool blankets was 1/5 blanket per bed and the highest, 1½ blankets. The lowest ratio for mixed wool and cotton blankets was 1/6 blankets per bed for an 80 per cent wool content and the highest was 2 blankets per bed for a 50 per cent wool content. When blanket purchases are greater than 4/5 per bed it is time to investigate the reason for this waste. Even 4/5 blankets per bed annual purchase can usually be reduced.

Caution about judging on wool content alone is advisable because the method of cleaning is an important factor in the life of a blanket. The laundry may either increase or decrease blanket replacement regardless of kind or quality of materials. In some hospitals careless laundering has led to the adoption of a very low wool content in blankets, and one hospital is even considering cotton blankets for universal use. It is generally admitted, however, that the all wool or high wool content blanket is more desirable because of its appearance and warmth, but laundering must be done with care to prevent shrinkage.

The technique of washing wool blankets varies from the regular laundry routine. The wash and rinse water must be approximately the same temperature and not above 98 degrees, and there must be no injection of live steam or cold water while the blankets are in the washer. Soap must be of a high grade and free from alkali which would remove the natural oil of the wool. The washer must not be packed full. Only a few blankets should be washed at one time and plenty of water should be

used. Blankets should be dried at a low temperature, or, if possible, air dried. After drying they should be fluffed to maintain appearance and warmth.

One hospital, finding that laundering was unsatisfactory for all wool and 75 per cent wool blankets, has resorted to dry cleaning. An arrangement was made with a dry cleaning establishment to clean the blankets at the rate of twenty-five cents apiece. Blankets in hospital service are cleaned four or five times a year and those in the nurses' home, once a year. This method of cleaning, together with the purchase of high quality blankets has reduced replacement to only 20 per cent. This hospital has been commended for the beautiful condition of its blankets. A blanket that looked newly purchased in its finely fluffed state had been in service for over three years.

The hospital which has difficulty with laundering blankets may find the dry cleaning method a practical solution. Some hospitals, however, wish to sterilize blankets after use so that every patient has a freshly washed, steam sterilized blanket. In such instances it is absolutely essential to use only cotton blankets. Hospitals which send their blankets to commercial laundries have found that blankets containing 50 per cent wool give the best service.

The adoption of an all wool blanket with bound edges for private and semiprivate service and a 75 per cent wool blanket for wards and nurses' home has proved an economical distribution in an eastern hospital. Blankets containing 75 per cent wool, with bound edges, gave longer wear in this hospital but were much harder and stiffer than all wool blankets and therefore were not satisfactory in the private rooms. A light plaid was selected.

The Most Commonly Used Colors

Another eastern hospital has a regular ward blanket that is 60 per cent wool. It is solid white with bound edges. This color was chosen because a white blanket requires a better grade of wool than does a colored one, and longer wear can therefore be expected. In addition to the ward blanket, a 100 per cent wool oxford gray blanket with a whipped edge is supplied for night and porch use. Plaid and solid color blankets are used in the doctors' quarters and nurses' home. Careful laundering and good quality blankets have kept replacements down to 25 per cent.

White, gray and plaid are the colors most generally used and in approximately this order, although plain colors in the lighter hues are used in some hospitals. In selecting colored blankets it is well to remember that blue and orchid are not always fast colors.

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IT'S THE MANY LITTLE KINDNESSES HAT MAKE IT SO COMFORTABLE HERE



MEN, too, like the cool, green color of Palmolive . . . the olive green that is nature's own beauty trade-mark. Each cake of Palmolive contains olive and palm oils . . . the centuries-old ingredients that make skin soft, smooth. No bleaches . . . no artificial colors, just the natural green of olive oil makes Palmolive green.

Supply your patients with Palmolive. In spite of its prestige it costs no more than ordinary soaps! We will gladly send you, upon request, our new free booklet and prices of Palmolive in five special sizes. Your hospital's name on the wrappers with orders of 1,000 cakes or more.

ELL, I'll be leaving you soon, Miss Smith. So before I go, I'd like to tell you how thankful I am for all your kindnesses. You and all the nurses and doctors have been simply wonderful."

"Thank you. We try to make our patients as comfortable as possible here."

"I should say you do! And you succeed in a thousand ways. Why, you've even provided me with my own favorite toilet soap.'

"You mean Palmolive?"

"Yes. And that means a lot to me, because Palmolive is the only kind I'd ever dream of using at home."

"That's just it. You see, we've found out there are a great many women who feel exactly the same way. So we've simply standardized on Palmolive.'

"I'm not surprised. Because it's true that more women use Palmolive for the complexion than any other soap. Taking that into consideration, I think, is just typical of your thoughtfulness. It's just one of the many things that make it so comfortable here."

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Dietetics and Institutional Food Service

Conducted by Anna E. Boller, Central Free Dispensary at Rush Medical College, Chicago

Teaching Gastro-Intestinal Patients How to Eat

By SARAH ELKIN

Dietitian, and

JACOB MEYER, M.D. Michael Reese Hospital, Chicago

N UNUSUAL method of dietetic and health instruction for gastro-intestinal patients has been developed in the Mandel Clinic, Michael Reese Hospital, Chicago. Every department in the Mandel Clinic has found it convenient to refer patients to the dietitian for dietetic instruction. The importance of dietetic control for the patients referred from the gastro-intestinal clinic was, of course, clearly apparent. The need for complete instruction and the large number of patients referred to the dietitian by this clinic resulted in the establishment of a gastro-intestinal class. The first class was started about six years ago, at which time one gastro-intestinal clinic was held each week, with about twenty-five patients attending. At the present time two gastro-intestinal clinics are held each week, with an average of sixty patients attending each clinic.

Class Work Stimulates the Patients

The patients either are referred from the general medical clinic for special gastro-intestinal diagnosis or they are patients in the hospital sent to the gastro-intestinal clinic for further observation.

Patients come to the clinic at 9 a.m. The doctors are scheduled to begin work at 10:30 a.m. A half-hour is required to register, weigh and take the temperatures of the patients. Instruction is given during the remaining hour. An announcement is made at the beginning of the class to the effect that the patients will be called for their appointments as soon as their doctor arrives. This announcement relieves the anxiety of the patients, and they relax and are ready to enjoy the hour of instruction.

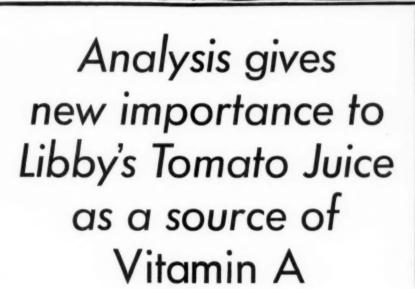
Group work stimulates the individual patient by

making him realize that he is not the only person in the world thus afflicted. Instead of indulging in self-pity, he becomes intensely interested in the talks, demonstrations and charts. The men patients are urged to bring their wives, or the person who prepares the food at home, to the class. If the latter cannot come during the regular clinic hours, special appointments are made for their instruction.

The food clinic classroom is well adapted to this type of work. The atmosphere is pleasant, interesting and informal. The room is attractively decorated. It contains potted plants placed in decorative bowls, and tables that seat four persons. Figured draperies are at the windows. The light green pots, pans and dishes that are used in the demonstrations offer a pleasant contrast to the furnishings.

The classes are attended by men and women who range in age from sixteen to seventy years. Gastro-intestinal complaints are numerous, but when the diagnoses are classified they fall roughly into the following groups: (1) gastric and duodenal ulcers in various stages, (2) colitis, (3) gallbladder disease and (4) constipation. The lectures center about these subjects. In order to make the discussions more interesting and more easily understood, pictures of the digestive system are shown and the course of food is traced in a simple manner.

The dietitian begins the instruction with an explanation of the essentials of the normal diet. She then explains that the special diets for gastro-intestinal disease simply are modifications of the normal family diet. Detailed explanations are given of the so-called soft or gastro-intestinal diets. Patients are told that they frequently can answer



 A series of biological assays, conducted over a period of eleven months, has proved that the Vitamin A content of Libby's Tomato Juice is unexpectedly high.

The importance of this Tomato Juice as a source of Vitamin A may be estimated from these figures which are in terms of Sherman & Munsell units:

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Whole Mi	k 65													
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Libby's Tomato Juice is made ex-

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Your patients and your staff will thoroughly enjoy the appetizing fresh-tomato goodness of Libby's gentle press Tomato Juice. Its many uses and low cost make it a wise addition to your purchasing list. Order, today, from your usual source. Libby, McNeill & Libby, Chicago.

*Sherman H. C., Chemistry of Food and Nutrition, MacMillan, New York, 1932, p. 365

FREE to dietitians and hospital buyers . . a full size 13½ oz. can of Libby's Tomato Juice. (Offer good until July 31, 1933.) Send coupon to Dept. N—42, Libby, McNeill & Libby, Chicago.

These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Red Raspberries Tomato Puree Corn, Beets Corin, Beets
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Spinach, Kraut
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Chili Sauce California Fruits Spinach, Kraut Jams, Jellies Pork and Beans

Salmon

Olives, Pickles Evaporated Milk
Mustard Mince Meat
Bouillon Cubes Boneless Chicken
Beef Extract
Peas Santa Clara Prunes
Catchup in Syrup
Chili Santa Strawberries Loganberries California Asparagus

Name Title Hospital Address

THE



An informal atmosphere surrounds the food clinic class. The patients are encouraged to ask questions.

their own questions about certain foods. They are told that if they can answer "yes" to the following three questions regarding any food it is permissible for them to eat it: Is it cooked? Is it smooth? Is it bland? This diet, with modifications, may be used in certain stages of ulcer, colitis and spastic constipation. How the family diet may be modified to meet the needs of the patient without having to cook extra foods is explained.

Food demonstrations are conducted; foods are prepared and samples are passed around for the patients to taste. This gives an informal atmosphere to the class, and encourages the patients to ask questions. Much to our surprise patients are often unfamiliar with the preparation of such articles as a poached egg, a custard or scraped beef. Those who are inclined to be skeptical usually are won over after sampling the dishes prepared for them.

The following foods usually are prepared and demonstrated for the class: cereals and cereal gruels; eggs, soft, poached and coddled; custards, soft and baked; toast, plain and milk; purée of vegetables; purée of fruits; cream soups (white sauce foundation with purée of vegetables); puddings, tapioca, cornstarch and bread; gelatin des-

serts; fruit whips, prune, apricot and apple; scraped beef, and beverages.

The dietitian uses the least expensive food preparations in her discussions and demonstrations so as to emphasize the fact that a special diet is possible without additional expense. She also tries to show that the food planned for the family may be adapted for the patient, and that in many cases the entire family may eat and enjoy such foods as cream soup, creamed fish or apricot whip, which the diet may include. It is extremely important for patients to leave the class feeling confident that their dietary instructions are easy to follow and will involve no great hardship. One of the chief worries of patients is the thought that a special diet involves additional expense. The social service department helps to budget the families if extra food is necessary.

The dietitian emphasizes the point that a proper diet is as important as drugs for gastro-intestinal patients. The importance of small, frequent feedings is explained, and the cost of foods is also discussed.

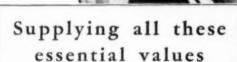
It is important to remember in dealing with clinic patients, that in order to reach each individual it is necessary to present information in

Either way...in a PINEAPPLE CUP

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Two Slices

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- 1. Canned Pineapple is a generous source of vitamins A, B, and C.
- 2. It furnishes the minerals that safeguard against nutritional anemia—iron, copper and manganese. And it supplies notable amounts of calcium and phosphorus.
- **3.** It helps effectively to prevent acidosis by contributing to the normal alkalinity of the blood.
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For daily use, Canned Pineapple is recommended. Canning processes cause a beneficial change of dietetic importance.

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ONE OF THE most delicious, most economical fruits you serve. And as revealed by recent studies, one of the most valuable, too—for dietetic reasons.

Canned Pineapple has been shown to contain more essential nutritional values, and to meet more known dietetic needs, than any other fruit which has undergone like studies.

Notice these many newly discovered values, in the panel at left. Realize that they are *combined* in this one fruit. Based upon soundly established tests on human subjects—these findings justify the new im-

portance of Canned Pineapple for daily use.

It is adaptable to obesity, highcaloric, anti-anemic, anti-constipation, as well as other restricted diets. These, besides its general use in full diets and on children's trays.

And, in whatever way you serve Canned Pineapple, the cost is always low. Particularly in the forms pictured here...each four cents or less.

That is why—in addition to the dietetic reasons—you can serve the fruit in a portion of two slices, or a Pineapple Cup of crushed or tidbits, at least once a day. Frequently, too, in salads and with meats.

the most simple way possible. Patients must understand clearly what the dietitian is talking about. Careful choice of words, and painstaking explanation, repetition and demonstration are necessary if the dietitian is to achieve success.

After being examined by the doctor, patients are referred again to the food clinic for specific diet instructions. A nutrition history is taken of each patient, covering the following points: age, height, weight, average weight, significant laboratory findings, bowel movement and food intake. Space is provided on the nutrition history card for indicating whether the diet provides adequate caloric requirement, bulk, protein, calcium, iron and vitamins. A record is also made of the diagnosis. The nutrition history is filed with the patient's permanent medical record. The patient is given a detailed written diet list for home use. Diet instructions are adjusted to the patient's activities, such as his occupation and home life. Complicated adjustments frequently must be made, and in such cases the aid of the social worker is of inestimable value.

Importance of Early Treatment Emphasized

Patients upon returning to the gastro-intestinal clinic are referred back to the dietitian for follow-up. The talk by the dietitian is followed by an informal talk by the chief of the gastro-intestinal clinic. The greater number of the patients already have been seen by the chief of the clinic, and therefore are anxious to attend the class.

The chief of the clinic usually opens his talk by explaining the importance of the gastro-intestinal tract to general health. These remarks serve as an introduction to the physiology of digestion and absorption. The importance of the early recognition of diseases, and the possibility of prevention in gastro-intestinal disease by early discovery are emphasized by the chief of the clinic in his talk. These points are illustrated by taking the history of some one patient in the class and using his illness as a concrete example. It is made clear to the patients that early recognition of gastric and duodenal ulcer and persistent medical management, properly supervised, will result in cure in 80 to 85 per cent of the cases.

The subject of cancer of the stomach is next introduced, and emphasis again is placed on the importance of early examination. The elementary symptoms, such as a coated tongue, belching, heartburn, constipation, diarrhea, emotional upsets and nervous stomach, are explained. The importance of a thorough examination by a competent physician is stressed, as are special tests and x-ray examinations when indicated.

Gastric ulcer is then discussed in detail as

many patients fall in this group. Gastric ulcer is best described to the layman by comparing it to an ulcer of the finger at the phalangeal articulation, which is irritated by motion or rubbing. The need of complete gastric rest and the importance of a smooth diet are illustrated in this way. The effect of digestive peristalsis is likened to the irritation of the ulcer of the finger. The gastric juices are likened to raw acids or other irritants.

The character of the food again is illustrated at this point, and questions are often asked by patients, who are told, often to their delight and astonishment, that they may eat ground or minced meat. The possible reasons for a recurrence of the illness and the influence of emotion, fatigue, infection, the nature of the disease and the limitations in certain cases are discussed. The danger from failure to adhere to the diet is pointed out. The physician is likened to a friendly policeman whose duty is to remind the patient of what he must not do. The rôle of medications and the various forms of treatment are outlined. Patients are told the importance of follow-up work and the need of frequent reports.

Colitis and gallbladder disease are likewise explained in a simple manner. Patients are encouraged to ask questions. Most patients take a great deal of interest in the lectures.

Continuous class instruction has resulted in more intelligent cooperation on the part of patients. The large attendance at the classes, the enthusiasm of the patients and the favorable reports of the clinic physicians indicate that we are achieving our goal.

A Valuable Book for Teachers of Dietetics

"Food in Health and Disease," by Katherine Mitchell Thoma, director of dietetics, Michael Reese Hospital, Chicago, should be enthusiastically received by all who are engaged in the teaching of dietetics to student dietitians, nurses or medical students. The material is presented briefly and concisely, and with sufficient detail to make it readily understandable.

The book is divided into three parts. The first part describes the most recent discoveries in the field of nutrition. The second part is devoted to the subject of "Diet in Disease," and is based on the theory that all therapeutic diets should be modifications of the normal diet, with such restrictions as will suit the needs of the patient. This section also contains some excellent suggestions in the form of sample menus and diet outlines which will be helpful to the busy dietitian.

The third section, entitled "Laboratory Outlines," will be of particular interest to dietitians who are teaching dietetics to nurses, for it has been carefully planned to conform to the outline approved by the American Dietetic Association. 6

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NEWS OF THE MONTH

A. H. A. to Conduct Institute for Hospital Administrators

THE American Hospital Association announces that plans have been completed for an Institute for Hospital Administrators to be conducted by the association in Chicago beginning September 18 and continuing until October 6. The University of Chicago, through its school of business, the American Medical Association and the American College of Surgeons will cooperate in the management of the Institute. Invitations to participate have been extended to the Catholic Hospital Association and the American Protestant Hospital Association.

Hospital administrators enrolled for the institute may go first to Milwaukee to attend the annual convention of the American Hospital Association in session from September 11 to 15, inclusive. Immediately after the close of the institute, they will have opportunity to attend the annual conference of the American College of Surgeons in Chicago the week of October 9.

The aim of the Institute for Hospital Administrators is to offer men and women professionally concerned with hospital management a brief period of instruction in hospital organization and administration and of observation and discussion of hospital problems. Most of the lectures and discussions will be conducted at the University of Chicago, and those enrolled will have the privilege of living in university dormitories at the usual student rates. The university, however, assumes no educational responsibility for the course and gives no university credit to institute students.

No certificate or diploma will be awarded, although each student satisfactorily completing the institute will be given a letter to that effect signed by the secretary of the American Hospital Association.

To be eligible for enrollment a student must have a good education and must have had experience in a hospital as superintendent, assistant superintendent, superintendent of nurses or business manager, or must have filled some other responsible position involving administrative hospital problems. Only registered students may attend institute sessions since American Hospital Association officials feel that discussions, lectures and periods of observation of hospital work will be most valuable if the student body is made up of persons with similar interests and experiences. Members of religious orders who are required by rule to attend such courses in company with members of their own Sisterhood may have such associates who will not be required to register.

Didactic lectures by hospital and medical authorities and members of the faculty of the University of Chicago school of business will occupy the first two weeks of the institute. The third week will be devoted to special problems selected by students, and to field studies in Chicago hospitals.

Students will assemble at 9:30 a.m., Monday to Fridays, inclusive. Morning periods will be devoted to lectures and discussions under the direction of leaders in the hospital

field. Institute students will spend four afternoons a week visiting selected institutions to study plants, equipment, organization and management of individual departments. These tours are made possible through the cooperation of the Chicago Hospital Association and its member institutions. Saturdays, Sundays, two afternoons a week and all evenings will be open for study, recreation and visits to A Century of Progress, where Saturday, September 16, has been designated as "Hospital Day."

Requests for application blanks should be addressed to the Executive Secretary, American Hospital Association, 18 East Division Street, Chicago. Blanks must be filled out listing fully the applicant's previous education, experience, positions held and other facts, and must be returned before August 15. An admissions committee appointed by the association will consider the applications, which must be accompanied by the registration fee of \$5. This fee will be returned to any applicant who fails to qualify for enrollment.

Flat Rate Plan Is Successful at Evanston Hospital

An experiment in a flat rate for hospital services, which has been tried at Evanston Hospital, Evanston, Ill., for a full year, is working out successfully, according to Ada Belle McCleery, superintendent of the institution. The flat rate charge is based on the price of the room selected by the patient and includes complete service except for the physician's fee. Thus when a patient enters the hospital he decides what price room he will be able to afford, ranging from \$7 a day up to \$20.

Whatever the patient's requirements, no matter how much attention he receives or how long he stays, his bill is computed by the number of days multiplied by the daily rate.

Computation of the rates charged was made after a close check of all patients' charges over a six-month period, to discover whether it might work out in practice. It was discussed by the board of directors for two years prior to that time.

At first glance, according to Miss McCleery, the rates per day appear slightly higher than the average under the old system, but in actual practice the total bill is much lower, as indicated by the records of 7,000 patients who have taken advantage of the system. The theory is that there will be an increase in bed occupancy, thereby lowering the unit cost

An article giving fuller information on the operation of this plan will appear in an early issue of The MODERN HOSPITAL.

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NEWS OF THE MONTH



"Economy in Operation" Is Keynote of New Jersey Convention

Practical solutions to present day problems as affecting hospitals throughout New Jersey occupied the attention of over one hundred members of the New Jersey Hospital Association at their ninth annual convention, held May 19 to 20 at Asbury Park.

Economy in operation was the keynote of the meeting, while other moot questions brought before the assembly included the matter of group insurance and better distribution of hospital facilities. The meeting, scheduled to start the morning of May 19, was postponed to the afternoon in order to enable the visiting hospital executives to take advantage of the spring sunshine which flooded the popular New Jersey resort. This proved of benefit in ensuring a larger audience for the opening discussions.

Antoinette Cannon, New York School of Social Work, was the first speaker, selecting as her subject "The Place of the Hospital in a Changing Social and Economic Order." "The community must support the hospital," Miss Cannon emphasized, "instead of that support coming solely from private sources. The hospital is a community investment, and the health it produces is the community's profits." A discussion of the points advanced by Miss Cannon was led by Dr. Ellen C. Potter, New Jersey Department of Institutions and Agencies. Members of the association were welcomed by Dr. R. W. Watkins, president, Monmouth County Medical Society, and the response was made by Marie Louis, president-elect, New Jersey Hospital Association and superintendent, Muhlenberg Hospital, Plainfield.

Business Problems Discussed

The program proceeded with a talk by Dr. C. E. A. Winslow, vice chairman, Committee on the Costs of Medical Care and dean, Public Health Service, Yale University School of Medicine, who outlined in detail the findings of the committee and urged, "If we are not satisfied with conditions as they exist today, let us not drift."

A change in the announced program introduced a discussion by Dr. Peter Marshall Murray, National Medical Association, on the health problem of negroes in New Jersey. Doctor Murray urged that hospital facilities be granted negro doctors possessing the required credentials. The Hospital Service Plan as practiced in Essex County was presented by Frank Van Dyk, executive secretary, Hospital Council of Essex County, and Josephine Sutfin, dietitian, Essex County Hospital, Cedar Grove, read a paper on "The Human Element in the Dietary Department."

Following a banquet at which the talks were largely informal, the members assembled early Saturday morning for a busy day. The major part of the program comprised seminar groups under the direction of Rev. John G. Martin, superintendent, Hospital of St. Barnabas and for Women and Children, Newark. William J. Ellis, commissioner, New Jersey department of institutions and agencies,

Alexander M. MacNicol, C.P.A., and Victoria Smith, director, school of nursing, Englewood Hospital, Englewood, led discussions on hospital economies, uniform hospital accounting and nursing administration, respectively.

Leaders of the afternoon groups were Eva Caddy, director, school of nursing, Hospital of St. Barnabas and for Women and Children, Newark, and president, New Jersey League of Nursing Education; Edgar Hayhow, superintendent, Paterson General Hospital, Paterson, and Dr. George O'Hanlon, chairman, New Jersey committee on public relations, medical director, Medical Center, Jersey City, their subjects being respectively, "Future Trend of Nursing Education," "Relations of the Hospital Administration" and "Public Relations of Hospitals."

Marie Louis was named president of the association at the closing session; William J. Ellis, president-elect, and Charles F. Dwyer, assistant superintendent, City Hospital, Newark, executive secretary.

The sixth annual convention of the New Jersey Occupational Therapy Association was held coincident with the meeting of the New Jersey Hospital Association.

New Hospital Is Opened in Wisconsin Town

The Langlade County Memorial Hospital, Antigo, Wis., was opened recently for the reception of patients. The new hospital is situated on a five-acre plot of ground. The building is two stories high, with basement, and 172 by 42 feet in ground dimensions. In the center is a section three stories in height. The frame of the structure is heavy steel beams on a concrete foundation, and the walls are of brick, lined with hollow tile.

There are rooms for patients on the first and second floors. The building contains two operating rooms, a laboratory, an obstetric room, a nursery, x-ray rooms, a laundry and a modern kitchen. The administrative offices are on the first floor. Plans for the new hospital were drawn by Van Ryn & De Gelleke, Milwaukee. Sister McIntosh is superintendent of the institution.

Announcement has been made of the closing of two small hospitals in Antigo—the Antigo Hospital and the City Hospital.

Michigan Hospital Association Postpones Meeting

The Michigan Hospital Association has changed the arrangements for its annual meeting, and instead of meeting in Detroit during the month of June, as originally planned, the annual meeting of the association will be held some time in the fall.

Dr. E. T. Olsen, director, Receiving Hospital, Detroit, is president of the association, and Robert C. Greve, assistant director, University Hospital, Ann Arbor, is secretary.

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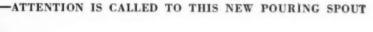
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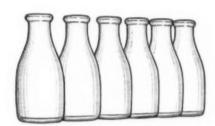




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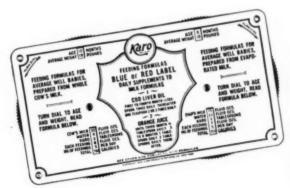
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This convenient calculator of feeding schedules is accurate, instructive and helpful. The makers of Karo will gladly send one to you on receipt of your name and address. Write to Corn Products Refining Company, 17 Battery Place, New York City.

NEWS OF THE MONTH

Iowa Dietitians Elect Officers at Meeting

At the semiannual meeting of the Iowa State Dietetic Association, held recently at Marshalltown, Dorothy I. Anderson, Iowa State College Hospital, Ames, was elected president of the association, and Ruth Ann Melvedt, St. Luke's Methodist Hospital, Cedar Rapids, secretary.

Among those who addressed the meeting were Kate Daum, director, department of nutrition, University of Iowa Hospital, Iowa City; Marian Zichy, superintendent, Visiting Nurse Association, Marshalltown, and Dr. Julian Boyd, University of Iowa Hospital, Iowa City. On the second day the dietetic group met jointly with the Iowa Hospital Association.

Provident Hospital Moves to New Quarters

Provident Hospital, Chicago, moved into its new quarters on May 15. On that date many of the patients in the hospital were transferred to the new building, and all new admissions were referred to the new building. The official opening of the hospital will take place June 1. The new quarters of the institution are at 426 East Fifty-first Street, the former home of the Chicago Lying-in Hospital. The building has been completely remodeled, and modern facilities and equipment have been installed.

Admiral N. J. Blackwood is medical director of the hospital.

Catholic Hospitals Make Ready for Annual Convention

The program has been completed for the eighteenth annual convention of the Catholic Hospital Association, which will be held in St. Louis, June 12 to 16. The majority of the convention activities will be housed under one roof, the gymnasium of St. Louis University. The general meetings, the sectional meetings and the exhibits will all be held in the cymnasium.

On Monday morning, June 12, there will be a solemn pontifical mass at St. Louis Cathedral. The formal opening of the exhibits will occur on Monday afternoon.

The convention will open on Tuesday morning, with the Rev. Alphonse M. Schwitalla, St. Louis University, president of the association, presiding. The president's address, various reports and the appointment of committees will feature this session.

There will be three sectional meetings on Tuesday afternoon, covering the following subjects: laboratory and x-ray service, dietetics and physical therapy and occupational therapy.

The Wednesday morning program also provides for three sectional meetings, the general topic being special services. The following subjects will be covered at these three meetings: nursing service, out-patient service and nursing education. On Wednesday afternoon the guests will be taken on a tour of St. Louis and then will visit St. Stanislaus Seminary, Florissant, Mo.

A general meeting will be held on Thursday morning, at which financial policies of the Catholic hospital will be discussed. The Rev. Maurice F. Griffin, Cleveland, will be the presiding officer.

There will be three sectional meetings on Thursday afternoon under the general topic, special services and departments. The subjects for the three meetings are: medical staff administration, medical records and pharmacy and medical social service. Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, Chicago, will discuss medical staff organization in the small hospital, and also the hospital standardization program of the American College of Surgeons.

The executive business meeting will be held on Friday morning, at which time the annual reports will be rendered and the officers elected. A general meeting will follow at which religious aspects of the Catholic hospital will be the subject. There will be a general business meeting on Friday afternoon, when the new officers will be installed.

Committees Appointed for Council on Community Relations

Dr. S. S. Goldwater, New York City, chairman, council on community hospital relations and administrative practice of the American Hospital Association, has announced the appointment of the following committees:

Committee on hospital medical practice—Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison, Wis., chairman; Dr. G. Harvey Agnew, Canadian Medical Association, Toronto; Dr. Michael M. Davis, director for medical services, Julius Rosenwald Fund, Chicago; Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, and Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore.

Committee on nursing—Dr. C. W. Munger, medical director, Grasslands Hospital, Valhalla, N. Y., chairman; Dr. B. W. Black, medical director, Highland Hospital, Oakland, Calif.; Dr. A. K. Haywood, superintendent, Vancouver General Hospital, Vancouver, B. C.; Mary L. Hicks, executive secretary, Louisville Health Center, Louisville, Ky., and Dr. Frederic A. Washburn, director, Massachusetts General Hospital, Boston.

Committee on accounting—Dr. Basil C. MacLean, superintendent, Touro Infirmary, New Orleans, chairman; Maurice F. Griffin, Cleveland; Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, Ill., and Dr. W. S. Rankin, Duke Foundation, Charlotte, N. C.

The American College of Surgeons has been informed of the desire of the council to place upon a more formal footing the relations between that organization and the American Hospital Association, and a cordial response has





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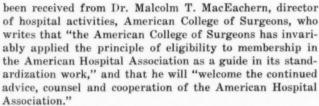
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Including casters, a wide variety of trucks, operating tables, wheeled stretchers, dressing carriages, food conveyors, rubber bumpers.

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NEWS OF THE MONTH



In a communication addressed to Dr. George F. Stephens, president, American Hospital Association, Effie J. Taylor, president, National League of Nursing Education, writes that "the board of directors of the National League of Nursing Education instructed me to express our readiness to join with the American Hospital Association in any study it may desire to undertake to the end that we may each have the opportunity to make whatever contribution is ours in solving the problems inherent in the nursing service and in the care of patients in our hospitals and in the community. We shall welcome the privilege of assisting to build a close and cooperative program." The aims and views of the National League of Nursing Education, as expressed by Miss Taylor, are in perfect accord with those of the council of the American Hospital Association which, through its committee on nursing, is now formulating a plan of cooperation.

Steps are under way for associating with the committee on accounting, in an advisory capacity, a group of experts in hospital accounting procedure.

Standards Suggested for Anesthetic Piping Systems

Recommended good practice requirements for the construction and installation of piping systems for the distribution of anesthetic gases and oxygen in hospitals and similar buildings and for the construction and operation of oxygen chambers were presented for adoption as a tentative standard at the annual meeting of the National Fire Protection Association, which was held at Milwaukee, May 29 to June 1. The regulations were prepared by the N.F.P.A. committee on gases at the request of the National Board of Fire Underwriters and with the cooperation of the hospital authorities of the country including the surgeons general of the Army and Navy and the U. S. Public Health Service.

The need for a code of suggested good practice has been brought about by the requirements for gases used in connection with anesthesia and for the therapeutic uses of oxygen in the larger hospitals. These are such that for convenience and timesaving, piping systems for the distribution of these gases to the various operating rooms have been widely installed. In case of leakage or rupture of any part of the piping system dangerous conditions may be created with some of these gases which have flammable or anesthetic properties or the property of supporting and promoting fire (as in the case of oxygen).

The report of the N.F.P.A. committee on gases which includes the above mentioned requirements is available in an advance publication on request to the National Fire Protection Association, 60 Batterymarch Street, Boston.

Chicago Hospital Will Discontinue Nursing Course

Enrollment of student nurses at Wesley Memorial Hospital, Chicago, has been stopped, and its three-year course in nursing will be discontinued. The present group of students, however, will be permitted to complete their studies and will receive their diplomas.

This school has been affiliated with Northwestern University since 1906. Through this connection, the board of trustees hopes to develop a nursing course of university grade, which will lead to a bachelor of science degree with a diploma in nursing.

Hospital Social Workers Will Meet in Detroit

The American Association of Hospital Social Workers has completed an interesting program for its annual meeting, which will be held in Detroit, June 12 to 16. The National Conference of Social Work will meet in Detroit on these same dates, and the hospital group will hold several joint sessions with the National Conference and its associate groups.

The hospital social workers will open their convention on Monday afternoon with a business meeting, where results of the year's activities will be presented.

On Tuesday there will be a joint luncheon with Division 3 (Health), and the National Tuberculosis Association. Marguerite Ridler, director, social service, Glen Lake Sanatorium, Oak Terrace, Minn., will preside. Dorothy Ketcham, University Hospital, Ann Arbor, Mich., will preside at the session which will follow the luncheon, and at which health insurance will be the main topic. Michael M. Davis, director, Julius Rosenwald Fund, Chicago, will speak on "Group Insurance in Relation to Present Day Medical Practice." Constance B. Webb, social service director, University Hospitals, Cleveland, will be the discusser.

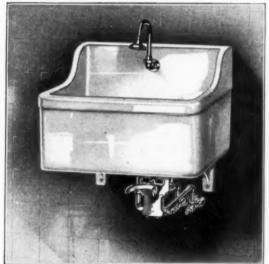
On Thursday afternoon the hospital group will meet for luncheon, at which time they will be addressed by Elma B. Pyke, Mount Sinai Hospital, Cleveland, whose subject will be "The Relation of Emotional Factors to the Patient's Physical Condition." Grace B. Ferguson, assistant professor, hospital social work, Washington University, St. Louis, will preside at the meeting following the luncheon.

The fifteenth anniversary banquet will be held on Thursday evening, with Elizabeth G. Gardner, University of Minnesota, president of the association, presiding. Antoinette Cannon, New York School of Social Work, New York City, will be the principal speaker.

On Friday afternoon there will be a joint meeting with the committee on social work with eye patients. Eleanor P. Brown, secretary, National Society for the Prevention of Blindness, New York City, will preside. "Problems of the social worker assigned to part-time service with eye patients" will be discussed at this session.

The executive committee will hold a meeting on Sunday, June 11.

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NEWS OF THE MONTH

Finances and Administration Major Topics at Ohio Meeting

E CONOMIC problems were of the greatest interest at the meeting of the Ohio Hospital Association, held in Columbus, May 2 to 4. There was a registration of 144 delegates, the largest in the history of the association.

John R. Mannix, University of Cleveland Hospitals, Cleveland, was elected president-elect, and A. E. Hardgrove, superintendent, City Hospital, Akron, was appointed secretary of the association.

The meeting opened with an address by Mary A. Jamieson, Columbus, president. Miss Jamieson told the delegates that the program had been developed especially to aid the hospitals of the state in meeting their financial problems.

Byron W. Stewart, chairman, legislative committee, reported on the efforts of that group to secure passage of the motor vehicle bill, which would provide for reimbursement to hospitals for services rendered to indigent victims of automobile accidents. Mr. Stewart stated that his committee hopes to secure passage of this bill at the present session of the legislature.

Clara Brouse, chief, Ohio State Board of Nurse Examiners, spoke on the present day trends in nursing. Miss Brouse called attention to the fact that the number of schools in the state had decreased from seventy-nine in 1931 to seventy-three at the present time. It was pointed out that nine of the seventy-three remaining schools have an affiliation with universities, and that there was a tendency on the part of the schools to discontinue allowances to student nurses.

Dr. H. H. Dorr, chief medical examiner, Ohio Industrial Commission, spoke on the "Industrial Commission and Hospitals."

At the evening session, Dr. Bert W. Caldwell, executive secretary, American Hospital Association, spoke on community relations. He urged hospitals to originate an additional program that would establish a firm community relationship for the hospitals.

Frank W. Hoover, superintendent, Elyria Memorial Hospital, Elyria, read a paper on group hospitalization. Mr. Hoover reviewed the history of group hospitalization, and then discussed several of the plans now in effect, particularly the plan at Baylor University Hospital, Dallas, Tex. He cautioned against the commercialization of the plan, and against competitive plans in communities of more than one hospital. Mr. Mannix described a tentative plan which had been developed for the consideration of Cleveland hospitals, and conducted a round table discussion on each phase of the plan.

On Wednesday morning, Mr. Hardgrove conducted a round table session. One of the problems discussed was flat rates. Other topics of discussion were the admitting procedure, a standard basis for grading the patient's ability to pay for hospital care, the financing of hospital accounts through loan companies, and the extent to which efficiency should be sacrificed by rotation and enforced

absence of employees for the sake of giving employment to a greater number.

Charles E. Findlay, superintendent, Springfield City Hospital, Springfield, opened the afternoon session with an interesting paper on vacations, sick leave and professional discounts. Mr. Findlay's paper appears on page 58 of this issue.

Mr. Mannix proposed a plan for the development of hospital councils in the state, which calls for dividing the state into four districts. A full description of this plan will appear in an early number of The MODERN HOSPITAL.

Dr. E. L. Harmon read a paper describing the recently incorporated Hospital Finance Corporation of Cleveland. This is a corporation formed by Cleveland Hospitals for the purpose of financing hospital accounts on a deferred payment plan. All patients who are not able to pay the cost of their care at the time of admission, but who are not indigent, will be referred to this corporation.

There was a banquet meeting on Wednesday evening. Following the banquet Rev. M. F. Griffin, Cleveland, discussed the participation of hospitals in tax and relief funds.

Dr. J. H. J. Upham, dean, School of Medicine, Ohio State University, reviewed the report of the committee on the Costs of Medical Care.

Dr. E. R. Crew, superintendent, Miami Valley Hospital, Dayton, conducted a round table session on Thursday morning. The discussion was devoted principally to purchasing problems and methods and trends in nursing education.

Practical Program Makes Washington Conference Successful

The second meeting of the Washington State Hospital Conference was held at Tacoma General Hospital, Tacoma, May 27. The address of welcome was delivered by Samuel M. Jackson, president of the hospital's board of trustees.

The morning session consisted of demonstrations and talks on the various departments of the hospital by the department heads. Dr. Dale Martin, pathologist, Dr. Milo Harris, roentgenologist, and Signe Wold, director of nursing and their assistants, together with other department heads, had prepared a practical program.

The afternoon session dealt mainly with matters pertaining to hospital economics.

A proposal for the organization of a hospital medical insurance company doing a large health, accident and medical service business was presented by Claire Bowman, former director, state department of labor and industries, Olympia, and S. S. Snypp, insurance actuary.

The discussion on hospital economics was opened by Dr. H. J. Whitacre, past president, Washington State Medical Association, Tacoma. The subject of group hospitalization was then thrown open for general discussion. This was followed by a review of hospital legislation, and an outline of what may be expected in the way of favorable hospital legislation at the next session of the state legislature.

Alden B. Mills, recently appointed managing editor of The Modern Hospital, was one of the speakers at the conference.

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NEWS OF THE MONTH

Hospital Groups of Three States Favor Prepayment Plans

FATURED in the discussions at the joint meeting of the Illinois, Indiana and Wisconsin hospital associations held in Chicago, May 3 to 5, were the subjects of prepayment plans for hospital care, community relations and economies needed to meet prevailing conditions. Success in abundance crowned the convention, the fourth held jointly by these states. The registration was over three hundred.

The social events of the meeting were well attended and the generous entertainment provided by the program committee was received with warm approval. Two distinguished visitors from a distance attended the convention—Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man., president of the American Hospital Association and Dr. N. W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., president elect, American Hospital Association. Doctor Stephens presided at the Tristate luncheon. At the banquet, when Dr. M. T. MacEachern was toastmaster, Doctor Faxon gave an address, which appears on page 71 of this issue.

Officers elected or reelected by the three associations are as follows: Illinois—Clarence H. Baum, Lake View Hospital, Danville, president; Maurice Dubin, Mt. Sinai Hospital, Chicago, secretary; Indiana—Edward Rowlands, Indianapolis, president; E. C. Moeller, Fort Wayne, Lutheran Hospital, Fort Wayne, president-elect; Albert G. Hahn, Protestant Deaconess Hospital, Evansville, secretary; Wisconsin—Dr. R. C. Buerki, State of Wisconsin General Hospital, Madison, president (reelected); George Crownhart, State Medical Society, Madison, secretary (reelected).

A display of hospital supplies and equipment was an interesting feature of the meeting.

On the opening day Illinois and Wisconsin met together and Indiana had a separate program. In the morning the Illinois and Wisconsin groups under the chairmanship of J. Dewey Lutes, Ravenswood Hospital, Chicago, president of the Illinois association, took part in a round table conference conducted by Doctor Buerki.

The afternoon program for Illinois and Wisconsin took the form of an open forum conducted by Asa S. Bacon, Presbyterian Hospital, Chicago. Measures adopted in 1932 to meet economic conditions occupied the attention of the meeting.

Indiana's morning meeting was presided over by George W. Wolf, president of the Indiana association and the subject of discussion was the registration of nurses.

In the afternoon the president-elect of the Indiana group, Edward Rowlands, presided and also talked on the lien law. A symposium on group hospitalization followed his paper.

On Wednesday evening a joint meeting was held under the chairmanship of Charles A. Wordell, St. Luke's Hospital, Chicago, president of the Chicago Hospital Association. To this meeting were invited hospital trustees and members of medical staffs to share in a discussion of hospital and medical economics.

At this time Alfred C. Meyer, president, board of trustees, Michael Reese Hospital, Chicago, expressed the viewpoint of the hospital trustee in regard to group hospitalization, and advocated the adoption of measures of this nature which he believes will have both economic and social advantages for the community and will eventually create a reservoir of funds for hospitals.

On Thursday morning Mr. Lutes presided at a joint meeting of the three associations, devoted to a discussion of the widespread movement to make the public better informed as to the service and problems of hospitals. A unique and clever way of telling about the Evansville, Ind., plan of public relations was adopted by Albert G. Hahn and Mrs. Hahn, who carried on a "long distance" conversation in question and answer form at telephones placed at each end of the speakers' table on the platform.

At this session, in addition to the papers on the subject of public relations, a paper was given by Michael M. Davis, director of medical services, Julius Rosenwald Fund, on "The Organization of Community Councils." Mr. Davis named hospital problems the existence of which is the reason for councils, told what should be the aim of such councils and described methods being adopted or planned in different places to bring them into being.

On Thursday afternoon there was a joint session for all three associations. George W. Wolf presided.

Hospital Economies Are Discussed

Carl Erikson, architect, Chicago, spoke on economies in the engineering department and gave many good pointers on how these can be achieved. Economies possible through alterations and changes in the hospital building were outlined by H. Eldridge Hannaford, architect, Cincinnati.

The balance of this session was devoted mainly to a discussion of the various phases of dietary service at Presbyterian Hospital, Chicago. Representatives from the dietetic department of the hospital told what they are doing in their respective departments to keep food costs at a minimum.

Grace T. Crafts, Madison General Hospital, Madison, Wis., read an interesting paper on economies that have been effected in the housekeeping department of her institution. Edna H. Nelson told how savings have been made at Ryburn Memorial Hospital, Ottawa, Ill.

John C. Dinsmore, University of Chicago Clinics, and Dr. E. T. Thompson, formerly director, University of Indiana Hospitals, participated in the general discussion.

Practical economies for the hospital dietitian were described by Louise Yeomans Gilbert, director of food service, Evanston Hospital, Evanston, Ill., whose address opened the Friday morning session.

Elizabeth Tuft, dietitian, Wesley Memorial Hospital, Chicago, emphasized the importance of accurate cost accounting in dietetic departments.

Others who spoke at this session were: Dr. Thomas R. Ronton, Chicago; Louise B. Powers, medical social service, University of Chicago Clinics; Ralph M. Hueston, Silver Cross Hospital, Joliet, Ill.; Maurice Dubin, Mt. Sinai Hospital, Chicago.

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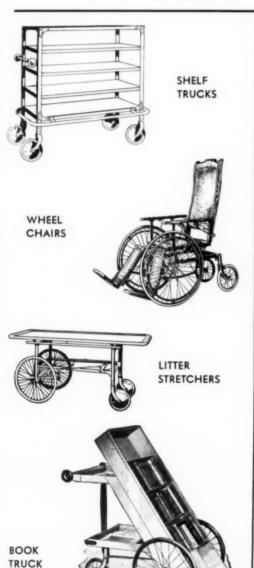
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PERSONALS

DR. CHRISTOPHER G. PARNALL, superintendent, Rochester General Hospital, Rochester, N. Y., has been appointed commissioner of public welfare for Rochester. Doctor Parnall's new appointment is to fill an emergency need, and it is not his intention to leave the hospital field permanently. Doctor Parnall is a former president of the American Hospital Association and became superintendent of the Rochester institution nine years ago.

LEONARD SHAW has been appointed superintendent, Saskatoon City Hospital, Saskatoon, Sask. Mr. Shaw has previously served as superintendent at General Hospital, Moose Jaw, Sask., and Swift Current General Hospital, Swift Current, Sask.

ELEANOR C. TILTON, superintendent of nurses, Riverview Hospital, Inc., Red Bank, N. J., since 1931, has been named superintendent of the hospital.

Dr. Henry A. Cotton, medical director emeritus, New Jersey State Hospital, Trenton, N. J., died recently. Doctor Cotton was appointed medical director of the hospital in 1907. He retired from active work at the institution in 1930, but continued as director of research.

R. A. Bates, superintendent, Ball Memorial Hospital, Piqua, Ohio, has resigned. Teresa Chalmers has been appointed acting superintendent of the institution.

Dr. B. A. Wilkes, superintendent, Southeast Missouri Hospital, Cape Girardeau, Mo., has retired from active service and has taken up residence in California. He will be succeeded by T. J. McGinty, formerly superintendent, Davis Hospital, Pine Bluff, Ark. Doctor Wilkes has been associated with the hospital field for many years, having held the superintendency at Missouri Baptist Hospital, St. Louis, and subsequently the same post at Hollywood-Clara Barton Memorial Hospital, Los Angeles.

Dr. S. A. NEWMAN has been appointed superintendent, Missouri State Sanatorium, Mount Vernon, Mo., succeeding Dr. E. E. GLENN.

ALBERT MORGAN DAY, a member of the board of managers, Presbyterian Hospital, Chicago, since 1902 and president of the board from 1904 to 1923, and since that time president emeritus, died recently.

DR. ROBERT P. C. WILSON, superintendent, Cedar Hurst Sanitarium, Platte City, Mo., has been appointed superintendent, Missouri State School, Marshall, Mo., succeeding E. E. BRUNNER.

Walter J. Grolton, superintendent, Missouri Pacific Hospital, St. Louis, for the past nineteen years, has been appointed superintendent, City Hospital, St. Louis, succeeding Dr. V. Ray Alexander. Dr. George A. Johns, formerly superintendent, State Hospital No. 2, St. Joseph, Mo., has been named superintendent, City Sanitarium, St. Louis, succeeding Dr. R. C. Fagley. Doctor Fagley is now superintendent, State Hospital No. 1, Fulton, Mo., succeeding Dr. T. R. Frazier, who has been appointed superintendent, State Hospital No. 3, Nevada, Mo. Dr. F. M. Grogan, former head of the latter institution, has been appointed superintendent, State Hospital No. 2, St. Joseph.

DR. JOHN ESCHEN-BRENNER, acting superintendent, Isolation Hospital, St. Louis, has been named superintendent of the institution. DR. ORAL S. McCLELLAN has been appointed superintendent, City Hospital No. 2, St. Louis, succeeding DR. FRED K. SLAUGHTER.

REV. EDWARD F. RITTER, general superintendent, Robinwood Hospital, Toledo, Ohio, since 1925, died recently.

DR. ALBERT E. BROWNRIGG, formerly in charge of Veterans Hospitals in Bedford, Mass., West Pennsylvania, Chicago and Sheridan, Wyoming, died May 3, in Nashua, N. H. DOCTOR BROWNRIGG was sixty-one years old, and had served as a major in the medical corps during the World War.

J. HOWARD JENKINS has been elected superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah, succeeding the late W. W. RAWSON.

MILDRED CONSTANTINE has been appointed superintendent, Quincy City Hospital, Quincy, Mass., succeeding RUTH J. Adie, whose resignation was announced recently. Miss Constantine was formerly superintendent of nurses, Montefiore Hospital for Chronic Diseases, New York City.

Dr. David W. Crombie has been appointed superintendent, Queen Alexandra Sanatorium, London, Ont., to succeed the late F. H. Pratten.

WILLIAM L. PARKER has been appointed purchasing agent, Hospital of St. Barnabas and for Women and Children, Newark, N. J. Mr. Parker has been supervisor of orders and stock, incandescent lamp department, General Electric Company, Newark, and has also served as president of the Purchasing Agents Association of New York for two successive terms.

OLIN L. EVANS has been named superintendent, Ashland State Hospital, Ashland, Pa., to succeed the late Horace D. LINDERWUTH.

Dr. Roy D. Halloran was recently named superintendent, Metropolitan State Hospital, Waltham, Mass. Doctor Halloran was formerly assistant to the commissioner, Massachusetts department of mental diseases.

DR. MERRILL F. STEELE, Fort Wayne, Ind., has been appointed superintendent, Grant Hospital, Columbus, Ohio, succeeding MARY A. JAMIESON.

Dr. Edward T. Thompson, administrator, Indiana University Hospitals, Indianapolis, resigned May 1. His successor is J. B. Howe Martin, purchasing agent and bursar at the hospitals.

HAROLD S. BARNES has been appointed superintendent, Dr. W. H. Groves Latter-Day Saints Hospital, Salt Lake City, Utah.

DR. WALTER R. KRAUSS has been named superintendent, Pennhurst State School, Pennhurst, Pa., succeeding DR. ALBERT H. SUPER, who has resigned because of illness. Since 1930, DOCTOR KRAUSS has been assistant superintendent, Wernersville State Hospital, Wernersville, Pa. ola-

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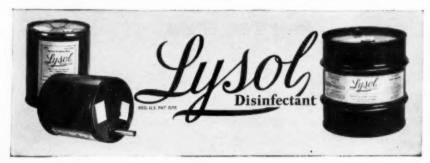
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NEWS OF THE MONTH

New York Social Service Units Will Hold Exhibits

Three large expositions of food products, hospital supplies and household equipment were opened in Greater New York, May 15, for the purpose of raising funds for the continuation of social service work in the municipal hospitals. These exhibits are being sponsored by the Associated Social Service Auxiliaries of the Department of Hospitals, Inc., a corporation formed under the laws of New York State and composed of official representatives of the many social service auxiliaries. They are to be held for three consecutive weeks in the 165th Infantry Armory, New York City, the 258th Field Artillery Armory, the Bronx and the 106th Infantry Armory, Brooklyn, respectively.

The program is being carefully worked out in conjunction with Dr. J. G. William Greeff, commissioner of hospitals, and other city officials.

Bellingham Hospital Undergoes Reorganization

Reorganization of St. Luke's Hospital, Bellingham, Wash., was completed recently. Since its establishment in 1892, St. Luke's Hospital has been managed by St. Paul's Episcopal Church. Under the new arrangement, the hospital has been incorporated as St. Luke's General Hospital, the church retiring from the management.

The present medical organization will be retained and the nursing school will be continued. The institution is in charge of practically an entire new staff of registered nurses and other experts, headed by Florence Corbett as superintendent.

C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, and president, Association of Hospitals of Washington, will be the adviser of St. Luke's.

A new wing was added to the hospital several years ago at a cost of more than \$100,000 and further improvements are contemplated.

Pennsylvania Dietitians Hold First Convention

The Pennsylvania State Dietetic Association held its first annual convention in Pittsburgh, May 5 to 7. The following officers were elected for the ensuing year: Mary Huhn, Moses Taylor Hospital, Scranton, president; Emma Smedley, Philadelphia, president-elect, and Dorothy O'Brien, Mercy Hospital, Scranton, secretary.

Helen Gilson, Pennsylvania Hospital, Philadelphia, showed motion pictures of the dietetic department at that institution, and W. C. R. Williamson showed motion pictures on the making of china. The afternoon was devoted to an educational trip to various institutions in Pittsburgh.

Group discussions were held on the morning of May 6. Dr. C. G. King, professor of chemistry, University of Pittsburgh, spoke on current progress in the chemistry of nutrition. Sister Mary Placide, Mercy Hospital, Pittsburgh, spoke on "What the student nurse should know about dietetics."

The morning of the final day was spent in visiting local hospitals, followed in the afternoon by a trip to Seton Hill College, Greensburg.

Buffalo Adopts New Plans for Medical Care

A new plan for medical service for the mutual benefit of the general public, the hospitals and the doctors was adopted recently by the Erie County Medical Society, the Buffalo Council of Social Agencies and the private hospitals of Buffalo, N. Y., after prolonged conferences. The board of managers of Buffalo City Hospital has endorsed the plan, which corresponds with the policies that have been in vogue at that institution for approximately fifteen years.

Under the new "Buffalo Plan," a patient is treated at the hospital or dispensary if his case is an emergency one. The family doctor, if indicated by the patient, is given a report of the patient's needs and his financial situation, and the doctor is given the opportunity of taking the case either on a part-pay or free basis if doctor and patient are agreed.

Lower Milk Prices Sought for New York Hospitals

Due to a regulation adopted by the Milk Control Board of New York State, department of agriculture and markets on April 17, known as Official Order No. 6, hospitals, charitable agencies and eleemosynary institutions in New York State are required to pay for milk and cream in accordance with the stipulated schedule as charged by the milk dealers to stores. On the other hand, the milk sold to the state, to a municipality, or to the federal government is not subject to these conditions. The latter groups are allowed to contract for their milk and cream supply with the lowest bidder.

In an effort to bring about a change in Official Order No. 6, Capt. Emil Greenberg, chairman, Bath Beach Community Council, Brooklyn, N. Y., has appealed to Herbert V. Lehman, governor of New York State, for assistance. Governor Lehman, in turn, has referred Captain Greenberg's letter to the Milk Control Board and has requested that goup to give consideration to the matter.

Captain Greenberg's letter to the governor points out that it is unfair, under present economic conditions, to compel hospitals to pay higher rates for their milk and cream supply by prohibiting them from asking for competitive bids. 0.6

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Admission Requirements for Student Nurses Changed

In order to make a better and more careful selection of students, a new routine of admission has been adopted by the school of nursing, Reading Hospital, Reading, Pa.

Prospective students report to the hospital on designated days during the month previous to the admission of their class and receive a thorough physical examination, an aptitude test and a test on spelling and arithmetic. Those who pass are required to make a deposit of \$50 for the preliminary course. For the first six weeks the students are not assigned to ward duty but as soon as they go to the wards they are given their caps. The preliminary course still extends over a period of four months.

Many Qualified Interns Now Available

As many interns are deferring their entry into practice because of present economic conditions, and are prolonging their period of institutional service, fewer places remain to be filled by this year's graduates. The Council on Medical Education and Hospitals of the American Medical Association therefore is requesting all hospitals approved for intern training that still have vacancies for interns to notify the council, stating how many vacancies each one has and the dates on which they desire them to be filled.

Coming Meetings

American Association of Hospital Social Workers.
President, Elizabeth G. Gardiner, University of Minnesota,

Merican Associated the Control of the City of Surgeons.

Minneapolis. Executive secretary, Helen Beckley, 18 East Division Street. Chicago.

Next meeting, Detroit, June 11-17.

American College of Surgeons.
President, Dr. J. Bentley Squier, New York City,
Director general, Dr. Franklin H. Martin, 40 East Erie
Street, Chicago.
Next meeting, Chicago, October 9-13.

American Dietetic Association.

President, Dr. Kate Daum, University of Iowa Hospital,
Iowa City, Iowa.

Business manager, Dorothy I. Lenfest, 185 North Wabash
Avenue, Chicago.
Next meeting, Chicago, October 9-12.

Next meeting, Chicago, October 2-13.

American Hospital Association.

President, Dr. George F. Stephens, Winnipeg General Hospital, Winnipeg, Man.

Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.

Next meeting, Milwaukee, September 11-15.

American Medical Association.
President, Dr. Jean De Witt Lewis, Johns Hopkins Hospi-President, Dr. Jean De Witt Lewis, Johns Hopkins Hospi-tal, Baltimore. Secretary, Dr. Olin West, 535 North Dearborn Street, Chi-Next meeting, Milwaukee, June 12-16.

American Protestant Hospital Association.
President, Rev. Thomas A. Hyde, Christ Hospital, Jersey City, N. J.
Executive secretary, Dr. Frank C. English, 3233 Griest Avenue, Cincinnati.
Next meeting, Milwaukee, September 8-11.

Catholic Hospital Association.

President, Rev. Alphonse M. Schwitnlla, St. Louis University, St. Louis.

Executive secretary, M. R. Kneifl, 1402 South Grand Boulevard, St. Louis,

Next meeting, St. Louis, June 12-15.

Connecticut Hospital Association.
President, Oliver H. Bartine, Bridgeport Hospital, Bridge-Secretary, Maud E. Traver, New Britain General Hospital, New Britain. Next meeting, Torrington, June 17.

International Hospital Congress. Next meeting, Knocke, Belgium, June 28-July 3.

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AN IMPROVED RUBBERIZED FABRIC

An improved rubberized fabric is now being offered hospitals by W. I. Young & Company, Watertown, Mass. The basic material is known as Sudanette-a fabric of exceptionally high quality, woven from long staple cotton. Combined with it is a layer of specially processed rubber welded permanently to one side of the fabric and guaranteed not to mildew, crack, check or peel. The material, known as Evercomfort Rubberized Sudanette, is both tubfast and sunfast and is readily laundered.

A similar product has previously been manufactured from Sudanette. However, the new Evercomfort product has been improved in three ways: (1) more rubber has been added per square yard; (2) all materials have been specially compounded to withstand laundering and sterilization better, and (3) imperviousness to oil has been made an added feature.

The advantages of Evercomfort Sudanette lie in the fact that the fabric is light in texture. Cotton on one side and rubber on the other make it desirable as a comfortable sheet, soft and cool, yet waterproof. It is supplied by the yard or in finished articles, and can be used by the hospital for sheets, aprons, garments and many other items.

A NEW MOVABLE CHAIR

The Royal Easy Chair Company, Sturgis, Mich., has recently brought out an interesting hospital chair with numerous features.

First of all, the chair embodies those well known advantages of an adjustable back and foot rest associated with all Royal Easy Chairs. However, the new product has added merit in that large rubber tired casters have been



mounted under the chair, a convenient wing table attached to one of the sides, and a bar handle fixed to the back to facilitate handling by the nurse or attendant.

As a piece of furniture in the patient's room, it should be found both useful and attractive. Its portable feature should facilitate the handling of the patient during con-

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offer their establishment at 65 E. Lake St., as Registration Headquarters for the Medical Profession during the

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Sharp & Smith hope that every doctor, hospital superintendent, or anyone affiliated with medicine visiting Chicago will make use of "Registration Headquarters" to locate any colleague who they have reason to believe may be visiting Chicago at the same time.

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For greater comfort of floor nurses many hospitals are now replacing old style chairs at floor desks with Ever-Hold Automatic Adjustable Steel Chairs. Ever-Hold Chairs are comfortable, light, strong, sanitary and are equipped with quiet casters. Without tools, they are instantly adjustable up or down to any fraction of an inch up to 10 inches.

Ever-Hold Automatic Adjustable Stools for Diet Kitchens

In the diet kitchens Ever-Hold Automatic Adjustable Steel Stools make the work of students easier by keep-ing them comfortable. The height of these stools is always right. Tall girls lower them to avoid unhealthy bending over. Short girls raise them to avoid tiresome reaching. All Ever-Hold Stools and Chairs are precision built and will last a lifetime. Write today for new Ever-Hold catalog and attractive prices.



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Baked banana is now part of the popular vegetable plate

Bananas BELONG in Hospital Diets

A RECENT writer for a leading hospital publication strongly recommends bananas because they are so agreeable and so well adapted to the digestion of sick people. As a matter of fact, there is scarcely a food on the hospital diet list which, for the money, combines and gives so much in nourishment . . . vitamins . . . minerals.

Bananas have an important place in fruit cups, fruit salads and are delicious and easy to serve as a vegetable—sautéed, broiled or baked.

Sliced bananas will retain their natural color for several hours if they are first kept for half an hour in a heavy, simple syrup (in the ratio of $1\frac{1}{2}$ cups of sugar to 1 cup of water). When used with canned fruits, sliced bananas will not discolor if covered with the syrup from the can. The easiest, most effective way is to place the sliced bananas in the bottom of the container, with the canned fruits on

top. Always use a silver or stainless steel knife for slicing...Coupon brings recipes for both quantity and individual serving. Send today.





Banana orange juice cocktail

The high food value and easy digestibility of the banana have been recognized by the Committee on Foods of the American Medical Association, and its acceptance seal granted for use in advertising by the United Fruit Company.



Bananas wrapped in bacon, then brostea

valescence and should minimize effort on the part of the nurse. The adjustable back and foot rest can be operated by the patient, thus allowing for complete relaxation or for an upright position for reading, service of food, visiting and so forth.

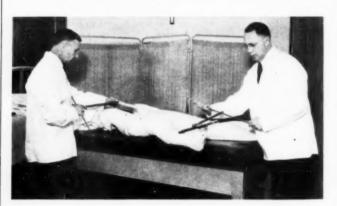
Because this new Royal Chair can be moved at will, it replaces the need for a wheel chair to a great extent. This, perhaps, eliminates some embarrassment to the patient who is likely to be sensitive about his disability. At the same time the patient can be taken from his room to any department of the hospital in a piece of furniture that is a part of his own room.

The chair is generous in size and is offered in a variety of upholstering materials.

NEW METHOD FOR REMOVING PLASTER CASTS

A simple device for the removal of plaster casts has been developed by the General Electric Company, Schenectady, N. Y. A cable, a roller upon which it is wound and a runway comprise the equipment. The rustproofed stranded cable is ½ inch or less in diameter, and the roller upon which it is wound works on the same principle as the key used to open a can of sardines. The specially constructed metal runway along which the roller travels prevents the roller from pushing against the cast, and leaves a space for the plaster as it is severed. The technique of preparing the cast for removal and the final sectioning are not difficult.

When the broken bone is ready for the cast, the steel cables are placed between the inner cotton bandages and



the layers of cloth that are impregnated with plaster of Paris. The cables should extend the full length of the cast, and be one or more in number, depending on the size, shape and location of the cast. It has been found that one cable may be used, but in most cases it is preferable to use two wires, on opposite sides of the cast.

When it is time to remove the cast, the free ends of each cable are attached to the roller key, and a few turns taken on top of the runway will sever the cast. It is better to use two rollers and turn them simultaneously toward each other. A cast can be removed, however, by securely strapping one end of the cable to the cast while the other end is wound on the roller, and then reversing the connections to complete the removal of the wire.

The wires should be placed at the time the cast is made, but it is possible to insert a cable beneath a cast which has been in place a long time, as it usually no longer fits tightly. In one case a cable was directed beneath a cast extending from the waist to the toes, over the inner curve of the ankle.

This equipment is equally effective for use with casts which are to be applied to crippled children as well as regular fracture cases.

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When plenty of light is desired this beside light can be set to give a veritable flood of light. If a subdued light is preferred, just tilt the shade and the room is bathed in a soft even glow of indirect light. For its convenience and serviceability, it is a welcome innovation in lighting equipment, because it serves excellently as a reading lamp, as a night light or for examinations or changing dressings.

51 inches from base to top, it can be extended an additional 24 inches if desired. Adjustable for height and lighting angle. Strong, well made, has an eight pound base. Beautifully finished in Bronze, trimmed with Gold; or Ivory enameled, trimmed with Green. A handsome, practical piece of equipment and very moderately priced. Be sure to specify finish desired when ordering.

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Coming to Wisconsin, this year? We hope so. But, wherever you are going, consult the Will Ross Catalog before you go and make up a list of items your hospital will need while you're away. We'll take care of deliveries on any date specified — Do this, now. Prepare for a really carefree vacation.



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CONSIDERABLE thought was given to make this a *bome* for the sick," says Mr. Charles E. Findlay, Superintendent of the beautiful new Springfield, Ohio, City Hospital.

So naturally beds at this hospital are equipped with Dwight Anchor Sheets—the soft, smooth sheets selected by millions of women for their own homes. Indeed, what other sheets could they choose that would have the luxurious rest-inducing quality so important in a hospital!

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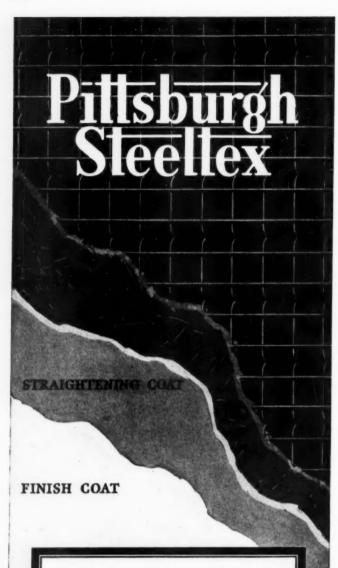
Their time-tested ability to withstand hard usage was another important factor in the choice of Dwight Anchors for the new Springfield City Hospital. Even after continual wear—when the hospital is no longer referred to as "new"—they will still retain their soft, smooth, linen-like finish.

Made of carefully selected cotton that never yellows with age, Dwight Anchors withstand treatment that destroys ordinary sheets. Countless launderings leave them still firm and durable. Expert tailoring lengthens their life. Selvages are firm—hems are sewed and resewed to guard against ripping. At these points of hardest wear there is no weakening.

The next time you buy linen, try out Dwight Anchor Sheets. Discover for yourself their fine texture . . . the economy of their long wear.

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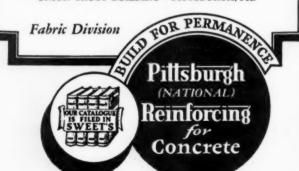
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THE PROPERTIES OF TONCAN IRON

A new folder has been published on Toncan Copper Molybdenum Iron by the Toncan Iron metallurgical department, Republic Steel Corporation, Massillon, Ohio. It gives a thorough analysis and description of the chemistry, physical constants and properties, usage, fabrication, treatment and resistance of this metal.

METHYLENE BLUE IN 50 cc. AMPULS

A recent advance in the treatment of carbon monoxide and cyanide poison has been made by the use of Methylene Blue. It is administered into the veins in a 1 per cent aqueous solution to the amount of 50 cc. Repeated use of this dosage since its first successful use at the Park Emergency Hospital, San Francisco, on September 5, 1932, has



confirmed its effect on both cyanide and monoxide poison victims.

In order to supply the hospital with this solution as a stock item, William H. Rorer, Inc., pharmaceutical chemists, 265 South Fourth Street, Philadelphia, have prepared a 50 cc. sterile ampul of the Methylene Blue 1 per cent aqueous solution.

AN ELECTRICALLY HEATED BASSINET

The Hospital Supply Company, 155 East Twenty-Third Street, New York City, has developed a new electrically heated infant incubator bassinet.

The bassinet is fully enclosed by the body of the carriage, except at the top. It is removable and is of ample size and depth to protect the infant and hold it comfortably. The carriage is fitted with a special device that permits the bassinet to be tilted to a head up or head down position. The angle of incline may be adjusted to any degree desired by means of a locking handle, without touching either the infant or the bassinet.

Within the body of the carriage and beneath the bassinet there is a series of heating units controlled by a three-heat switch, so that high, medium or low heat may be obtained. A pilot light with a ruby lens indicates when the current is on. The heating element may be plugged into any ordinary lighting system outlet. A thermostatic control may be had instead of the three-heat switch if desired.

The bassinet is mounted on a tubular stand that has large, easily moving wheels.

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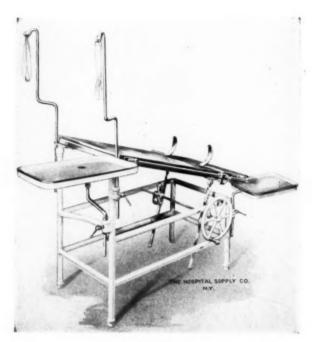
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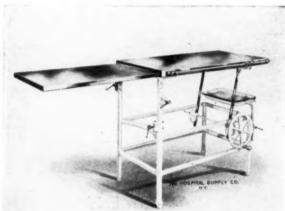
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"It is conceded by a number of hospital executives that a policy should be inaugurated granting to employees each year a certain number of days' sick leave with pay." Page 59.

"The hospital which has difficulty with laundering blankets may find the dry cleaning method a practical solution." Page 102.

"The chief sources of danger in an operating room today are not so much overt as covert. The system is usually correct in principle; the individual errs in carrying it out." Page 43.

"The dietitian uses the least expensive food preparations in her discussions and demonstrations so as to emphasize the fact that a special diet is possible without additional expense," Page 106.

"Calamities frequently unlock doors opening into new worlds of power and

happiness." Page 83.

"Accounting has only one correct principle and this principle can be applied to hospitals as well as to any other line of business." Page 47.

"Education for nursing has been an excuse for the hospital and the system in practice has been an easy financial escape for the student." Page 82.

"In her eagerness to do her work well the housekeeper is apt to forget that she is dealing not only with things but with people." Page 77.

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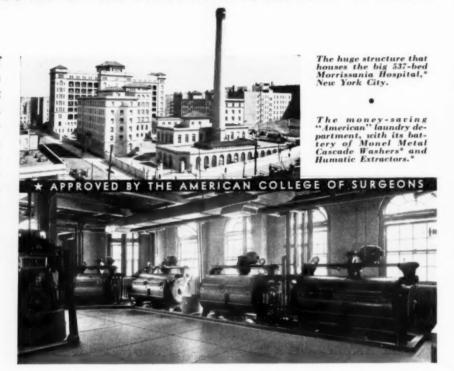
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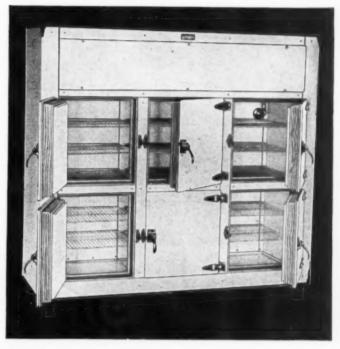
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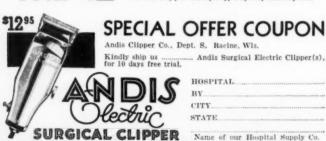
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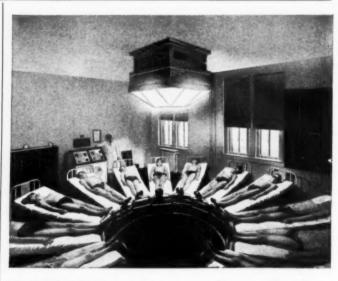
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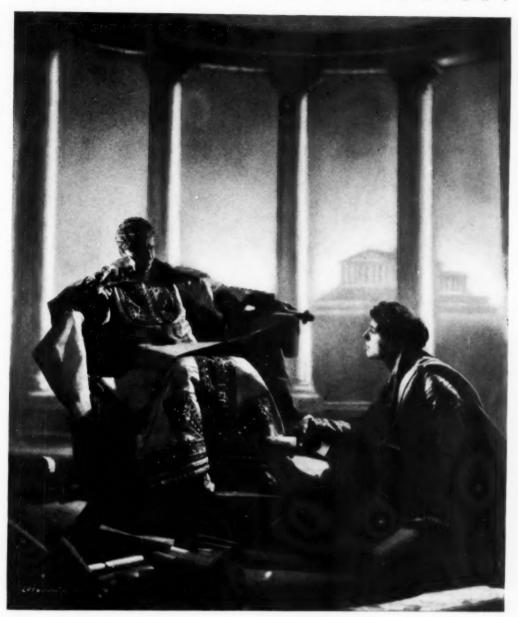
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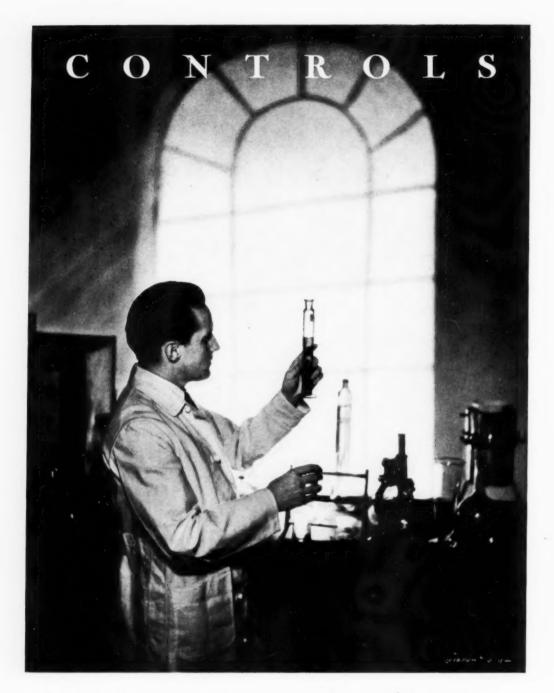
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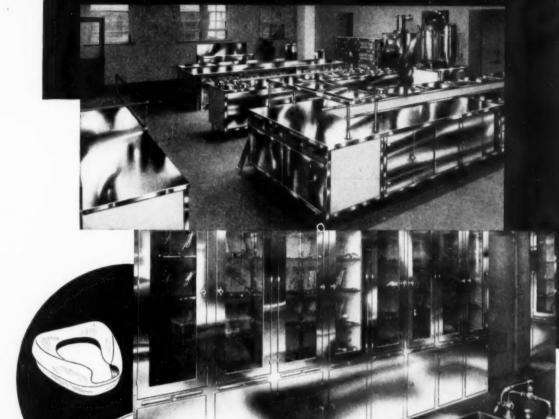
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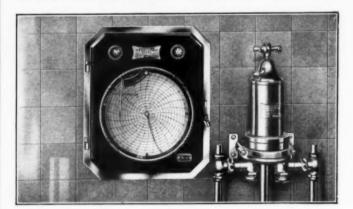
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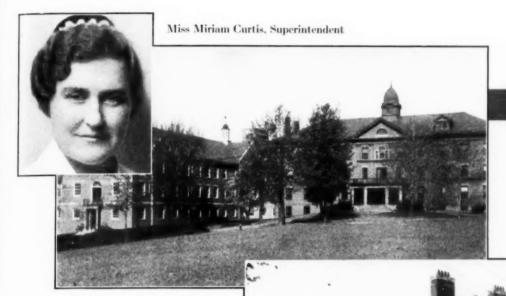
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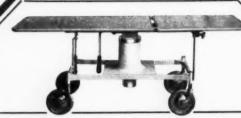
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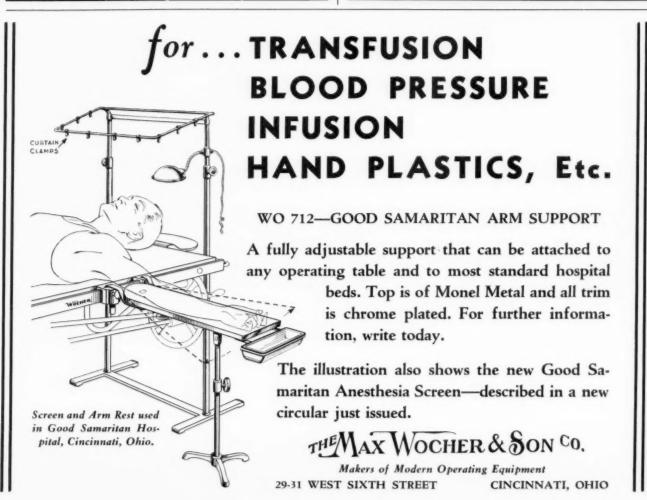
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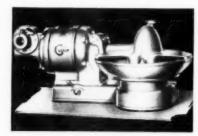
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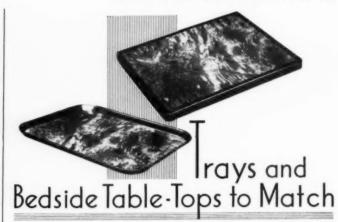
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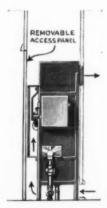
THE ZEPHYR 75



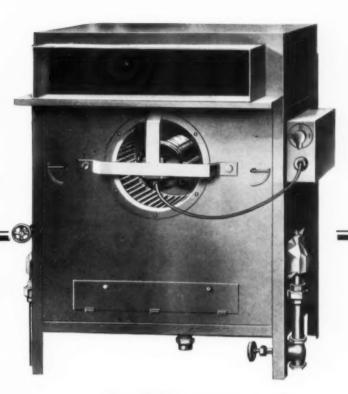
Above: Console enclosure, used when Zephyr 75 is installed in space served, replacing one ordinary heating radiator.

Below: Zephyr 75 concealed in wall, with access panel. Inlet and discharge

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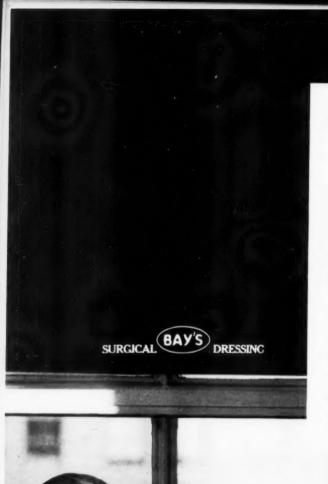
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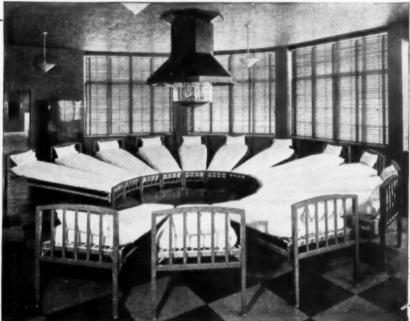
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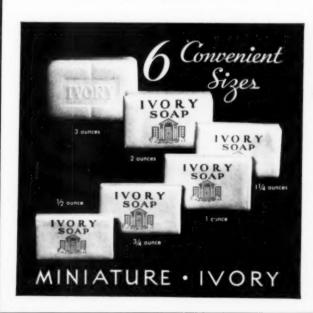
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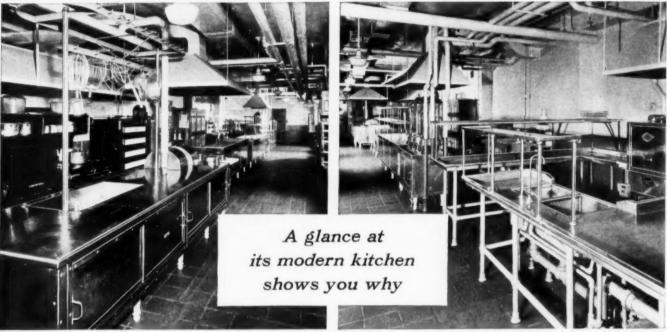
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● View of the kitchens of La Rabida Sanitarium, showing Monel Metal cook's table, serving counters and shelves. All the Monel Metal food service equipment manufactured and installed by ALBERT PICK COMPANY, INC., of Chicago.

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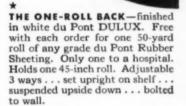
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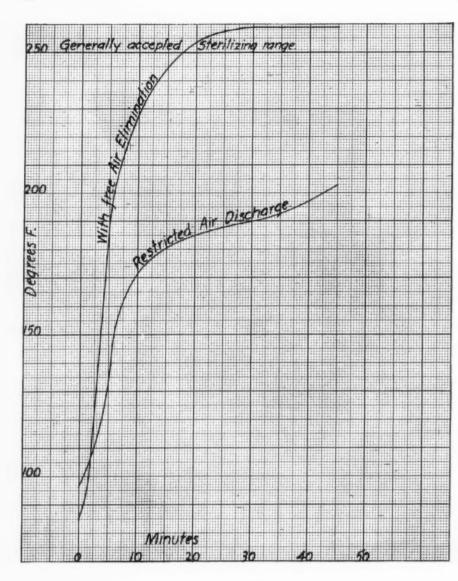
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ANAESTHETIST—Four years' experience as anaesthetist, during which time she has combined duties as anaesthetist with those of record clerk; prior to postgraduate training in anaesthesia, had two years' experience as obstetrical supervisor, 323,

ASSISTANT—To administrator or director of nurses; graduate of the Philadelphia General; B.S. degree; postgraduate training in public health nursing and pediatries; four years, supervisor of pediatrics, 200-bed hospital; three years, science instructing; two years, assistant superintendent of nurses, eastern hospital; will consider pediatric supervising, also. 324.

DIETITIAN—B.S. degree, Ohio State University; three years, dietitian, 65-bed hospital, where she has had charge of the housekeeping, planning all menues and all special diets. 325.

(Continued on page 136)



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- DIRECTOR OF NURSES—Graduate of Johns Hopkins, five years, night superintendent of university hospital; four years, superintendent of nurses, southern hospital of 150 beds, 327.
- EDUCATIONAL DIRECTOR—B.S., M.A. degrees; postgraduate training in supervision and teaching; five years in teaching department of university hospital. 328,
- INSTRUCTOR—Graduate of Lakeside Hospital, Cleveland; B.S. degree, considerable work toward Master's; six years in her latest position as science instructor on staff of 200-bed hospital. 329.
- INSTRUCTOR—B.A. degree, Smith College; year's experience as pediatric teaching supervisor; three years as practical instructor. 330.
- INSTRUCTOR—A.B. and graduate nurse degrees, state university; four months' supervising, Yale University Hospital; five years, instructor of nurses and assistant superintendent of nurses, 331.
- SUPERVISOR—Graduate of University of Cincinnati School of Nursing; three years, surgical head nurse on floor averaging 40 patients. 332.
- SUPERVISOR—Bachelor of Nursing degree from the Yale School of Nursing; two years, teaching supervisor, university hospital, 333.
- SUPERVISOR—Graduate of New England training school; postgraduate training in supervision and teaching; four years, supervisor of obstetrical floor; age 33. 334.
- SUPERVISOR—Postgraduate training in operating room technique; two years, operating room supervisor, 100-bed hospital; four years, supervisor, operating room department of 375-bed hospital, 335.
- SUPERVISOR—Graduate of New York hospital; postgraduate training in pediatrics at Yale; several years' public health work followed by two years' supervising (pediatrics); has done research work in infant behavior and child development. 336.
- SURGICAL NURSE—Graduate of Western Reserve University School of Nursing; year's experience as assistant head nurse in general surgery; age 24. 337.
- NURSE-TECHNICIAN—Year's training in x-ray and physiotherapy; four years' experience. 338.
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- INSTRUCTOR—Diploma in nursing large Eastern school; M.A., Western Reserve University; 6 years' experience as medical supervisor and instructor University School of Nursing; at present head of ward supervision, University School of Nursing.
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 4 years' experience as instructor; post-graduate Chicago Lying-In Hospital; 1 year's experience as educational director.
- SUPERVISOR—Diploma in nursing Johns Hopkins Hospital School of Nursing; 3½ years' experience as operating room supervisor.

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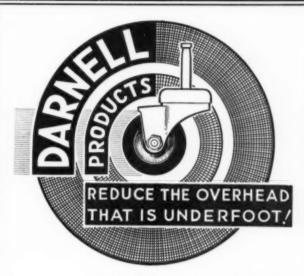
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(Continued on page 138)



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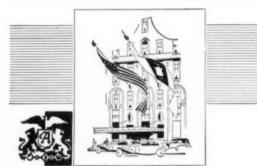
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- INSTRUCTORS—(a) Experienced science instructor; fairly large school; New England; \$125, maintenance. (b) Assistant instructor; duties teaching of practical nursing, follow-up work, relieving in office; year of college training required; New York; \$95, maintenance. (c) Science and practical instructors; preferably trained by Sisters and Catholics; eastern school; ninety students. (d) Theoretical instructor; fairly large school; eastern New York; splendid connection. (e) Science instructor; university hospital; B.S. degree required—Master's preferred. (f) Instructor for maternity hospital; special training in obstetrics as well as education required. (g) Practical instructor; large hospital; New York City vicinity. (h) Instructor; university hospital; duties: classroom teaching, supervision and supervisory instruction; nurse especially strong as supervisor of practical experience required. (i) Practical instructor; special preparation for teaching and 32 college credits required. (j) Instructor for both practical and theoretical subjects; 30 students; New Jersey. (k) Instructor for small school in far west. 347.
- SUPERVISORS—(a) Cultured, well trained woman about thirty-five who has had several years' successful experience as operating room supervisor; teaching hospital of more than 300 beds. (b) Chief operating room supervisor; 250-bed hospital; new well equipped surgical suite of six rooms; experience and teaching viewpoint required. (c) Operating room supervisor qualified to teach surgery to postgraduate students; university hospital; degree required. (d) Operating room supervisor who has had bronchoscopic experience; university hospital. 348.
- SUPERVISOR—Pediatric supervisor for university hospital; important position; duties consist of administration of pediatrics; ward classroom teaching and assisting in clinic work for medical students; \$150, maintenance; possibility of reduction; minimum of two years' college work required. 349.
- SUPERVISORS—(a) Obstetrical supervisor who has had graduate training or experience in contagion. (b) Supervisor for surgical floor; university hospital; \$100, maintenance. (c) Supervisor; 25-bed floor; New England hospital; \$90, maintenance. (d) Outpatient supervisor; small community hospital; social service or public health training desirable. (e) Obstetrical supervisor who has had postgraduate training in pediatrics, also; large hospital; California. (f) Pediatric supervisor; college trained woman qualified to organize course for postgraduate students required. (g) Contagious supervisor for university school offering course in contagion; special preparation in contagion and teaching experience required. (h) Supervisor for psychiatric ward of university hospital; degree and extensive psychiatric experience required. 350,

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(Continued on page 140)



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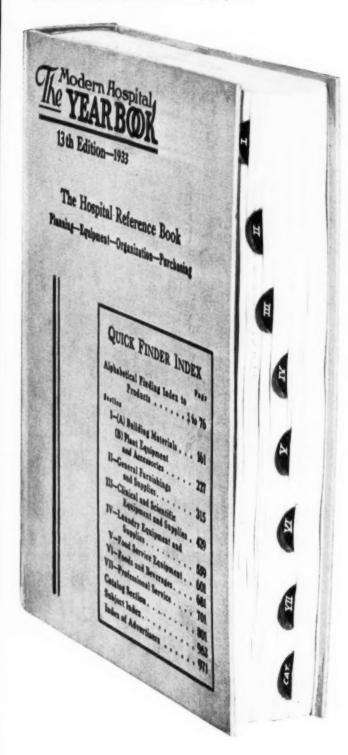
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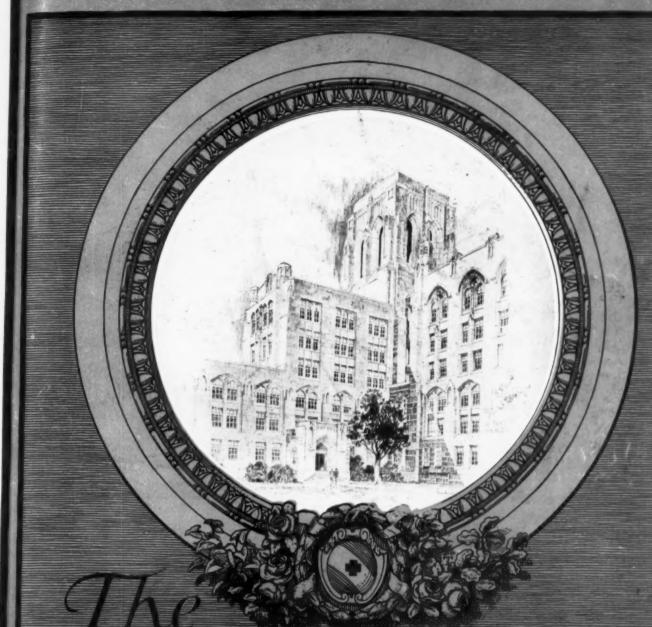
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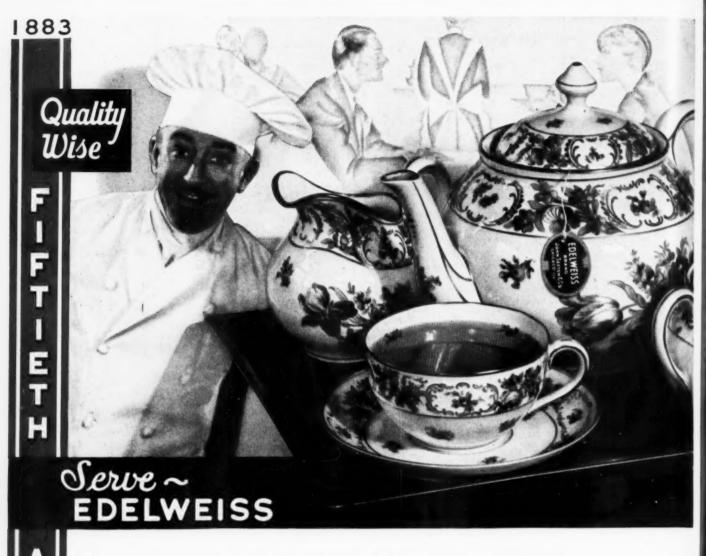


Vol. XL

JUNE, 1933

No. 6





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